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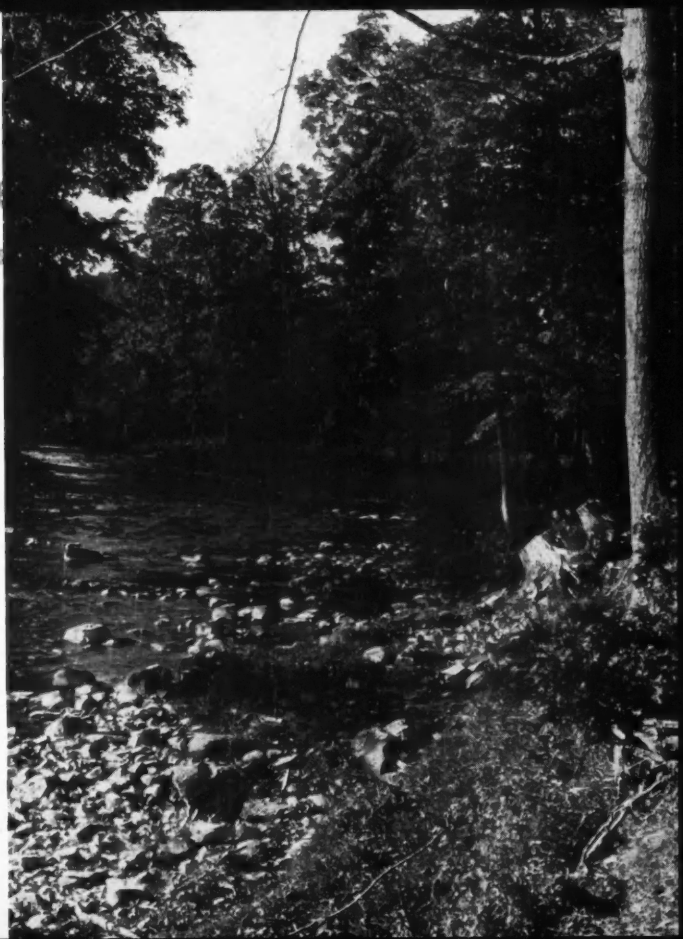
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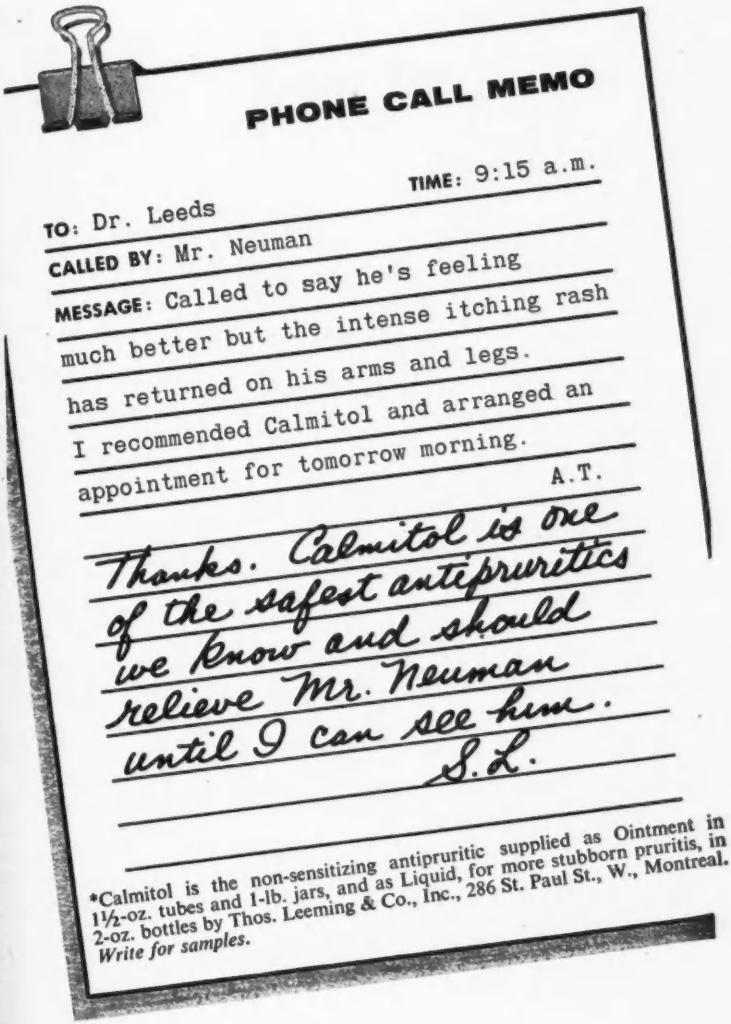


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THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 54 **NUMBER 9**

SEPTEMBER 1958

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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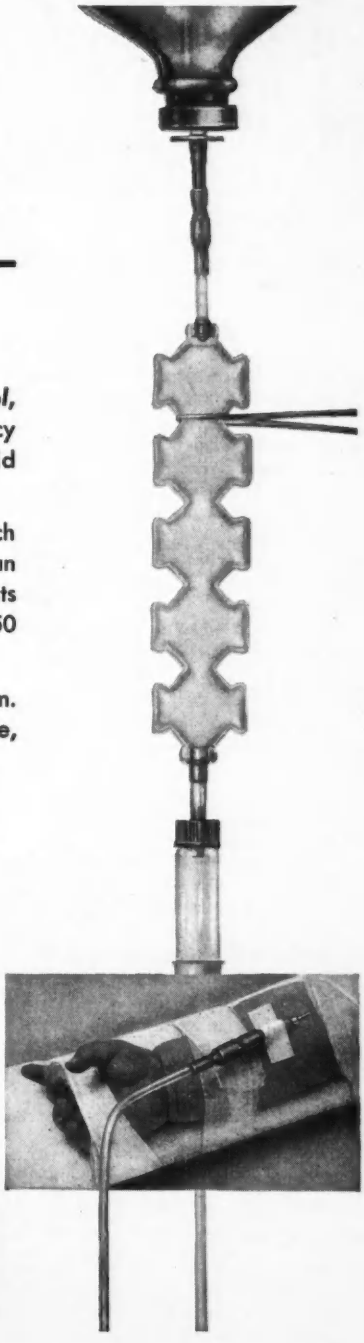
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Between Ourselves

THIS MONTH SEVERAL of the addresses delivered at the 29th General Meeting of the CNA are shared with you. Leading off is Miss **Trenna Hunter's** presidential address in which she reviews the functions of a professional organization and shows how our national Association has acted to fulfill its obligations. It boosts our present sense of pride in the CNA when we realize how much has been accomplished in a short time.

* * *

On the first day of July the machinery necessary to make the proposed National Health Program a reality went into operation. Five provinces are expected to participate almost immediately and four others hope to do so within a very few months. The possible effects of the scheme upon nursing has occasioned certain doubts and concern. Are our fears justified? You will be interested in reading the description of the scheme by the Hon. **J. Waldo Monteith**, Minister of National Health and Welfare, and his views concerning nursing under such a program.

* * *

One of the strongest impressions left upon each one of us by the Convention was its international air. This was due partly to the presence of representatives from so many distant countries, often in bright native dress. But the creation of this atmosphere was, in a large measure, due to the messages of two guest speakers. Miss **Agnes Ohlson** president of the International Council of Nurses, refreshed our memories concerning the functions of the ICN and our responsibilities as a member nation. Miss **Lyle Creelman**, World Health Organization, pushed back the boundaries as she made us realize that nursing is the same the world over — only the conditions under which and for which nursing care must be given differ. Both of these addresses are presented in this issue for your interest and pleasure.

* * *

One of the participants of the panel on "New Horizons" presented on the final day of the convention was Dr. **Aileen D. Ross**. Dr. Ross is a sociologist at McGill University and, over the years, has come in contact with many members of the nursing profession carrying out postgraduate study. Her interest in nurses and their work has led her to a study of the problems that they face and which tend to produce dissatisfaction. She expressed the opinion, as a panel member, that nurses need to be more aggressive, less afraid to label themselves as *intelligent* women — a term that she found consistently omitted in all descriptions of what a nurse should be. We are pleased to present in this issue, an address delivered on another occasion in which she outlines those factors that detract from a happy professional life.

* * *

After any occasion when you have had an especially good time, little incidents keep drifting back into your mind. Thus it is with the anniversary convention. We are treasuring a memory from the closing evening — a moment of warmth, humor and comradeship. Just before she installed the new officers for the succeeding biennium, Miss Hunter called Miss Daisy Bridges to the centre of the stage and asked her to accept a gift from the Canadian Nurses' Association for ICN House. The gift, as Miss Bridges revealed, was for "£92 ls lld" or $250 and is to be used in the purchase of a silver coffee service. Her stipulation that we should go to ICN House to make the coffee and that they, in return, would come over here to make the tea brought an understanding ripple of laughter from an audience, suddenly and warmly aware that ICN House in part belonged to them.

There is one other bit of information that may be of interest — this time from behind the scenes. You already know that there was a very efficient system of simultaneous translation in effect at the convention. But how many of you discovered that most of it was the work of a Scottish gentleman — Blake Hanna — whose pronunciation of English words still retains a delightful burr? We can't help wondering — did his French pronunciation have it too?

A guest towel is what often persuades people their hands don't need washing after all. —MARK TWAIN

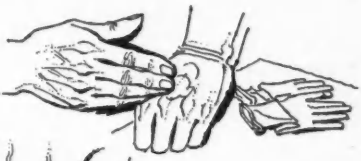
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Description—Isopropamide iodide ((3-carbamoyl-3,3-diphenylpropyl) diisopropylmethyl ammonium iodide) 5 mg. tablets; long-acting anti-cholinergic compound.

Indications—Peptic ulcer, hyperchlorhydria, pylorospasm, neurogenic, irritable or spastic colon, and other gastrointestinal disorders associated with hypersecretion or hypermotility.

Administration—Usual dose is one 5 mg. tablet every 12 hours, some patients with severe symptoms may require 10 mg. doses.

Contraindications—As for any potent anticholinergic agent: glaucoma, pyloric obstruction, prostatic hypertrophy.

MARCUMAR

Manufacturer—Hoffmann-La Roche Limited, Montreal.

Description—3-(1-phenylpropyl)-4-hydroxycoumarin, oral anticoagulant, with prolonged, uniform action.

Indications—Prevention and treatment of thrombo-embolic diseases.

PRO-TRAN

Manufacturer—Mowatt & Moore Ltd., Montreal.

Description—Promazine HCl (10-(3-dimethylamino-n-propyl)-phenothiazine HCl), tablets 10 mg., 25 mg., 100 mg.

Indications—Anxiety states, tension, restlessness, acute psychiatric states. Also has anti-emetic action and potentiates effects of analgesics and sedatives.

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Administration—Adults: mild infections: 2 capsules every 6 hours; **moderately severe infections:** 3 capsules every 6 hours; **severe infections:** 4 or 5 capsules every 6 hours.

Children: Due to its tolerance, may be administered to younger children and infants. In **moderately severe infections:** 50 mg. per kg. of body weight, per day; **severe infections:** 100 mg. per kg. of body weight, per day.

The usual precautions for antibiotic therapy should be observed. In meningeal infections, spiramycine is not active because its diffusion into the cerebrospinal fluid is not sufficient.

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Manufacturer—Geigy Pharmaceuticals, Montreal.

Description—3-(alpha-acetonyl-4-nitrobenzyl)-4-hydroxycoumarin.

Indications—Conditions for which anticoagulant therapy is normally employed.

Administration—Initial dosage is usually 20-30 mg. Induction is completed on second day by administration of 8-16 mg. Thereafter maintenance dosage is usually 2-10 mg.

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Manufacturer—Roussel (Canada) Ltd.; **Distributor:** Anglo-French Drug Co. Ltd., Montreal.

Description—1.5% Soframycin in a water-soluble vehicle.

Indications—Primary infection—folliculitis, furunculosis, boils and carbuncles, otitis externa, sycosis barbae, impetigo and ecthyma, perionychia. **Secondary infection**—secondarily infected cuts, scratches and wounds, burns, ulcers, eczemas, contact dermatitis, seborrheic dermatitis.

Administration—Remove scales and crusts from the lesion, spread the ointment upon it; cover with a sterile dressing. Renew daily and wash the affected part, if necessary, with tepid saline.

The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.

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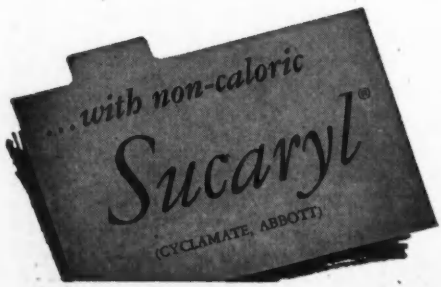
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THE CANADIAN NURSE

L'Infirmière canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 54 NUMBER 9

MONTREAL, SEPTEMBER 1958

Our Professional Association

OTTAWA, 1908, and Ottawa, 1958! One could wish for a long-range telescope that worked in reverse that would enable us to look in on the meeting that took place at the Lady Stanley Institute October 8, 1908. There, the foundation of our Canadian Nurses' Association was well and firmly laid. Our thoughts often turn to the founders of this Association and to the words that were written at that time.

Today, I shall speak on Our Professional Association, a theme that is so well developed by Dr. Robert Merton,* Professor of Sociology at Columbia University. He divides the functions of a professional association into three main areas: First, the *individual practitioner*:

> The most persuasive and far-reaching function of the professional association . . . consists in giving him social and moral support to help him perform his roles as a professional. The organization helps see to it that professional people need not try to cope with their professional problems alone.

The CNA has encouraged provincial associations to set up employment relations committees and to concern themselves with counselling and placement of members of the profession. Personnel policies have been made available to members, to employing bodies and to the public. In our personnel policies we have stated that allowance should be made for differences in preparation of the nurse and for differences in the responsibilities that she is asked to assume. The provincial associations which make up the CNA, have exercised a protective role in providing individual nurses with machinery for appeal in matters relating to conditions of employment and to their responsibilities as professional workers. But the protective functions of the association for its members is not limited to improving personnel practices. Encouraging the members to improve themselves is also

*The Functions of the Professional Association, Robert K. Merton, A.J.N., January, 1958.

an association responsibility.

When we sponsor institutes, send out itinerant instructors or give educational loans and bursaries we seek to improve the competence of individual members. Because education is a life-long process we keep encouraging our members to increase their knowledge.

It has long been the desire of the CNA to establish a pension plan for nurses but a plan to suit the needs of such a diverse group as nurses has proven difficult. Some are self-employed, some are working in agencies with well-established pension plans, some are in charitable institutions and some are in agencies where no plan exists. The proposal approved by our members will help the Association fulfil this aim of providing for the welfare of its members.

The profession tries to protect both its members and the public by seeing that individuals live up to the code under which we practise. Our Association's ideals are best expressed in the International Code of Ethics adopted by the Canadian Nurses' Association.

The second area of responsibility is for the *Profession*:

> The foremost obligation of the Association is to set rigorous standards for the profession and help to enforce them — always in the vanguard with standards more exacting for ourselves than the public would demand.

Over the past few years our profession has tried to fulfil this function — a few examples will suffice.

The Pilot Study to evaluate schools of nursing in Canada is well under way after many years of planning.

Different methods of educating nurses, such as the experiment in the Metropolitan School of Nursing at Windsor, the program of the Atkinson School in Toronto, the Centralized Teaching Program in Saskatchewan, to name only a few, have all been studied earnestly in an effort to determine what constitutes a good plan of education for nurses.

Since every profession has a responsibility for providing for the growth of its specialized knowledge, it is essential to encourage research by its individual members or by groups. Our professional association has lacked funds and qualified people to do as much as we would like in this regard but we have a number of studies and research projects completed and others are under way.

The Head Nurse Study, completed in 1956; the Cost Study of Nursing Education in Saskatchewan; the Study of Nursing Functions at Notre Dame, Montreal; The Study of Nursing in New Brunswick by Dr. K. Russell, have all added to our body of professional information.

A statement of the CNA policies for Nursing Education and for Nursing Service has been produced and is in use though we are not satisfied with the statements contained therein. Our committees have worked to improve them again this biennium.

This is as it should be — a profession should never be satisfied with the *status quo* but should always be striving for greater attainments even though it makes life in association work difficult at times! We have to be prepared for the inevitable criticism from some members, who feel that they will never measure up to higher and higher standards, so why have them? Criticism comes from other members who feel the profession is letting them down because standards are not high enough!

The third area is for *Society*:

> One of the Association's principal functions for the society of which it is a part is far from evident; it has often gone wholly unnoticed. This is . . . to help prevent the atomization of society into a sand heap of individuals each intent on pursuing his own private interests. The association mediates between the practitioner and profession on the one hand, and on the other, their social environment.

The responsibility of an organization is to foster good relationships among allied professions and between the association and departments of government. The relationships fostered over the years by our Association have been good. The general secretary's report includes a list of committees and Boards on which we have representation.

Our connection with the WHO through our membership in the ICN

helps us to become less provincial and hidebound in our thinking. One has but to recall the opportunities afforded many of our members to work on international committees, to realize how stimulating can be such experiences.

A part of an association's responsibility lies in its ability to function in an advisory role to departments of government. This role we have fulfilled in a number of commitments. We submitted a brief on nursing needs to the Royal Commission on Economic Affairs and in so doing projected our thinking to the year 1980. We have prepared a submission to the government on nursing needs in any proposed Health or Hospital Insurance plan. We have also provided a statement on nursing which was used by the Technical Planning group of the WHO for a world wide discussion on nursing. No "sand heap of individuals" responded to these requests. Thoughtful, careful submissions were prepared by members of the profession speaking through one voice, that of the professional association.

The Canadian Conference on Nursing, held in November, 1957, was an attempt by our profession to have some assistance from allied professions and from the public in helping to solve nursing problems. The professional associations in the provinces are constantly alert to monitor any legislation which might affect nursing. They are always ready to advise governments on any matters which could affect the standards of the profession.

When we look back over the past two years we feel sometimes that the great lumbering machine known as "Democracy" could be made to move a little faster. But when we look back over the 50 years of our Association's existence we feel that we have had a jet-propelled machine in our hands and that it has shot forward all too swiftly.

And now, what of the future of our Association? Dr. Leo Kanner has written:

> A Talmudic legend tells of a heathen who wished to be informed about the principles of Mosaic religion. Wherever he went his ears were filled with the din of sectarian debates, and he was incapable of finding the essence amidst the hair-splitting controversies about trifling details. He went to Shammai, a famous expounder and teacher known for his rigid and uncompromising views and asked for a concise statement which should take no longer than the time during which the enquirer was able to stand on one leg. This was utterly impossible he was told; it would take years of painstaking study for the uninitiated before he could grasp the very complex issues involved. Undaunted, the heathen went to Hillel, a celebrated scholar known for his gentleness and made the same request. Hillel, without a moment's hesitation, quoted from Leviticus, "Love thy neighbor as thyself." This he assured the man was the gist of all religion.

What if someone from within or outside our ranks should come and ask with similar insistence: "What does the nursing profession stand for? What does the profession want for nursing?" Could we answer as simply and as completely as Hillel? I doubt it. Too many images exist as to what nursing today really is — too many doubts assail us as to what is the right way to prepare nurses for the present-day needs, let alone for the unforeseeable future. Maybe it is not important to have one simple answer. After all, most advances in knowledge have been made by the pooled experiences of many people. As long as we have many nurses pondering deeply and thoughtfully we shall go on having more than one answer.

I feel that our founder, Mary Agnes Snively, would be proud of our progress to date but, as a true member of a great profession; she would not be quite content and would reiterate what she said 50 years ago — "It is therefore your privilege and, I may add, your duty, to be dedicated to the work thus far advanced, and into the future open a better way."

TRENNA G. HUNTER

One of the reasons why the Ten Commandments are so short and to the point is the fact that they were given direct and did not come out of a committee.

The most general survey shows us that the two foes of human happiness are pain and boredom.

—ARTHUR SCHOPENHAUER

The International Council of Nurses

AGNES OHLSON

I BRING GREETINGS from the officers of the International Council of Nurses to you, the members of the Canadian Nurses' Association. As you may recall, the ICN will celebrate its 60th Anniversary in 1959. The Canadian Nurses' Association has been an active member of the International Council of Nurses since 1909. In these 50 years I am sure you would say you have gained much from contact with world nursing through the ICN and also since 1948 through the World Health Organization. Certainly by means of these contacts Canadian nurses have made valuable contributions to the progress of nursing in the less privileged countries.

Nursing is making a tremendous impact on the health and living conditions of millions of people in all regions of the world. How have nurses become increasingly involved in world affairs? From what source do they draw their strength and their inspiration?

I believe that the influence nurses have on the world today, and the amount of responsibility they are able to carry, is not only dependent on their technical skill, essential though this is. It is due in no small measure to the fact, that wherever they are, and whatever the conditions under which they may be required to work, they *do not* work in isolation. Behind them, and supporting them, they have their own professional organization. Behind our national nursing organizations, there is our *international* organization, whose primary concern is with its member associations, its individual members, and the patients they serve. This international professional organization — the International Council of Nurses — has stood the test of time, having an unbroken history of 59 years. It has survived through two world wars and many minor wars. During more than half a century of existence it has built up bonds of friendship and fellowship among the nurses of the world which neither wars nor rumors of wars could sever.

This we owe to our nursing pioneers, those stalwart historical figures who, from the earliest days of professional nursing, realized that a profession organized, was a profession better equipped to give service. Nurses cannot accomplish, by their individual effort and volition, what an organized profession can accomplish on their behalf.

What then do we mean when we speak of our International Council to which we achieve membership through membership in a member association? What does it do? What are its objectives? How does it work? Why do we owe it our allegiance and our interest?

It was founded in 1899 at the end of a century when organization for women was practically unknown. Membership was offered at that time to national nurses' associations which could show that they fulfilled certain requirements: that they were governed solely by nurses; that they were non-political, not supporting any one political party; that in their membership they included nurses of all religious faiths.

Under this same constitution, which has changed very little in its essentials through half a century, the ICN has functioned to the present day and now numbers some 450,000 nurses organized in national nurses' associations in 46 countries. Besides the 46 associations which are in full membership, there are 17 other countries where the nurses have been granted national associate status. A nurse in each of those 17 countries has been appointed by our Board of Directors to act as a liaison between the nurses of that country and the ICN in order to help them towards full professional development. Some of these countries have already sent in applications for ICN membership and we hope we shall be able to welcome them as full members

Miss Ohlson is the president of the International Council of Nurses. She is also the chief of the Connecticut Board of Nurse Examiners, Hartford, Conn.

when the ICN Grand Council next meets in 1961.

To be both influential and useful, an organization must have both objectives and activities. The objectives of the ICN are simply to help in maintaining the highest standards of nursing service in those countries which are in membership, and to help those countries not yet in membership to meet the requirements which will enable them to join us. Yet another objective, and one that is just as important in these days of world instability and disunity in political affairs, is to promote in every way we can, friendship, fellowship, and understanding amongst the nurses of the world.

These are our objectives but what of our activities, and how is the work carried out?

The headquarters of the Association is in England. Here there is a small but busy office situated in a very historical part of the city of London. There, a staff of approximately twenty persons, six of whom are nurses, keeps in constant contact with our members throughout the world; trying to carry out their wishes and to help them with their problems; initiating and promoting activities which are likely to benefit professional work in all countries. At our headquarters, the ICN maintains an information centre, collecting information on nursing service and nursing education from all parts of the world and making this information available as and when required. Here too, relationships are established and maintained with the United Nations and its specialized agencies. We are indeed proud to be able to say that because we could claim to have a progressive, representative, and democratically constituted organization, we were one of the first nongovernmental organizations to be admitted into official relationship with the World Health Organization after it was established in 1948. We continue to be proud of our opportunity to further our objectives through the channels of the WHO.

The ICN has recently entered into relationship with another of the specialized agencies of the United Nations, the International Labor Organization. The ILO has been studying the conditions of employment of nurses throughout the world. Their questionnaires have been sent out by the ICN office. One of our active ICN members has been a temporary staff member in the ILO in the development of the report which that organization plans to present for discussion and recommendations at a meeting to be held in Geneva next October. The ILO, as you may recall, includes membership of three groups, namely, the employers, the government labor department, and the employees themselves. We look forward with great interest to the recommendations which this specialized agency will bring forth regarding the economic status of the nurse.

The ICN also has membership in the World Federation for Mental Health and the International Hospital Federation. On behalf of our members, representatives attend conferences and congresses of many nongovernmental organizations which, like ourselves, are concerned with health and social welfare.

The many thousands of nurses who are refugees from their own countries are our especial concern. The ICN maintains a Register of these nurses. We are always ready to assist in their re-establishment and to help them with their personal and professional problems. In undertaking this humane and vital work for our less privileged colleagues, the ICN has accomplished something quite unique which has been accomplished by few other professions. Those of us concerned with licensure of nurses from other countries, draw heavily on the resources of the ICN in establishing authentic information with relation to the status of schools of nursing in various countries throughout the world.

The organization of quadrennial congresses is an important activity of the ICN and only those who have participated can appreciate their value. First, there is the enrichment for all in the making of new friendships, the strengthening of past contacts, and the broadening of our outlook in the whole field of nursing. An international congress makes us realize that our professional interest cannot be confined by the boundaries of our own country. We are helped to acquire a statesmanlike outlook and to denounce insularity, realizing to the full

that nursing, above all other professions, is international in character, that it knows no boundaries of race or creed. At a Quadrennial Congress we listen to the presentation of various reports and enter into discussion about the content and recommendations. It is then that light seems to dawn on many previously unsolved problems. The newer trends towards which the profession is moving become clearer and we see their probable effect on future spheres of action in different parts of the world. Come to our next congress in Australia in 1961! I can promise you a rewarding experience and one that has real spiritual value enabling you to face your manifold responsibilities with a better understanding and a greater courage.

What can Canadian nurses do towards promoting world nursing?

1. Your Association can present the pattern for a strong organization — a pattern which nurses in other countries where the profession is more recently organized may wish to follow.

2. You can illustrate the value of maintaining high educational standards. Those countries which have good standards have a particularly vital role at this time. We must take definitive action on such questions of education as:

Is the program in education in nursing keeping pace with the education for the members of other disciplines in the health field?

What functions will the nurse of tomorrow be asked to perform?

Are we preparing the practitioner for the more complex and extended functions of the professional nurse of today, as well as the nurse of tomorrow?

Is the pattern of basic nursing education one that interests the best qualified graduate from our secondary schools?

Do we have an adequate number of qualified persons to teach in our schools and to administer our nursing service?

Are we, as nurses, engaging in research of our own functions?

Are we preparing nurses for research in our own field and to work with persons from other health disciplines in research relating to total health care?

Do we merit the status of being designated as a distinctive health science that is related to but separate from Medicine? Are we recognized as such?

3. Our activity as nurses in the field of legislation is an extremely important one for the protection of the public and for services to the public. We must take our rightful place; sometimes initiating legislation, sometimes backing legislation introduced by others, and sometimes taking action against various measures introduced in order that we will have fulfilled our responsibility for the passage of legislation that will be to the benefit of nurses and nursing and health. We, as nurse citizens, must also make our voice heard on questions of international concern. Through our national and international organizations we have the opportunity to glimpse the needs elsewhere. So matters of foreign aid, foreign trade, and defense are items upon which we should have a broad outlook which provides understanding for the needs of people of other nations.

4. Adequate and secure economic conditions are vital. It is important for nurses to establish their own bargaining procedures. It is true that we are regarded as and that we *are* a dedicated calling. This does not preclude the understanding by professional nurses that it is their right to expect a standard of living comparable to that of similar professions and vocations. It is their responsibility to find an orderly process by which this may be achieved for their membership.

5. Many of you will be hostesses for nurses from other lands. Give them of your wisdom and your experience, while at the same time holding out your hand of friendship and hospitality. When the process is reversed and the Canadian nurse has the opportunity of visiting other countries, she goes not only as an individual, but as an ambassador for the nursing profession. We as members of the ICN should feel a personal responsibility for the happiness of all other nurses from any other country so that the cause of internationalism is upheld.

6. The ICN works through its officers, its staff, and its committees. But never forget, the effectiveness of officers, staff and committees is determined by its membership. Active members of a strong and representative national organization provide cumulative resources for an effective inter-

national organization. Each Canadian nurse who can claim membership helps build the strength of the Canadian Nurses' Association, and in turn, a strong ICN.

Why is international work important? Actually, it is a necessity both for safety and for progress in this day of rapid transportation and communication. What happens in any one country has a direct and immediate influence on each one of us, whether it be in the realm of religion, in politics, in science, or more specifically in health. We must, therefore, have an active international association with well established two-way channels of communication to speak for us.

We, as members of the nursing profession, are a privileged group in that we possess knowledge and skills that are vital to the citizens of the world. Let us not forget that this privilege carries with it a responsibility to give and share in the same measure as we have been blessed. We must give of our knowledge and our dues, sharing a measure of both our human and material resources, in order that comfort and hope and health may be brought to those less privileged than we.

In the Good Old Days

(*The Canadian Nurse* — SEPTEMBER, 1918)

Twenty years ago the Victorian Order was founded and was the first public health nursing organization in Canada. In spite of discouragements and mistakes, the value of this form of nursing has become evident even to governments and "soulless corporations."

* * *

The course for nurses at Holy Cross Hospital, Calgary, has been changed to two years' training.

* * *

Public health work is distinctly patriotic. It aims to conserve life at its earliest foundations, to prevent disease, to care for the physical welfare of the individual and community. .

A flower sandwich can be prepared by placing a thick layer of nasturtium blossoms between thin slices of bread spread with salad dressing. Clover sandwiches are made by putting a small amount of fresh, unsalted butter in a self-sealing jar, filling the jar with fresh clover blossoms and leaving for several hours in a cold place until the butter absorbs the clover flavor.

* * *

In your work in the homes never be drawn into a discussion of race, creed or politics, no matter what your private opinion may be.

* * *

Let your manner of dress, while on duty, be an example to those with whom you work.

A method to detect "candidates for premature labor" and success in delaying such labor through use of the anticholinergic drug Dactil (piperidolate HCl) has been reported by an Idaho doctor. Since prematurity causes more than half of all perinatal deaths, methods of preventing premature labor and delivery are considered the greatest hope in reducing infant mortality.

Premature labor and delivery can be predicted by

a. Cervical dilation or thinning before the 32nd week of gestation.
b. A definite history of previous premature delivery or spontaneous abortion.
c. Multiple pregnancies.
d. Uterine cramping or bleeding.

Under such conditions Dactil therapy was initiated and continued through the 39th week of gestation or until delivery. A total of 39 patients with 109 pregnancies were observed both before and during the two-year study. The following report is based upon study of this group:

> Patients with premature dilation of the cervix when treated with Dactil gave birth to babies with a mean weight of one pound higher than with previous management. Only one abortion was encountered. In pregnancies prior to Dactil therapy, 21 abortions were encountered.
>
> — Science Information Bureau

Nursing in the World

LYLE CREELMAN

LAST DECEMBER leading nurses from 16 countries met in Geneva. They represented areas as far apart geographically as India, Australia, South Africa, Brazil. There were nurses from several European countries including Poland which has resumed active membership in WHO.

The discussions were centred on administration and the problems which face nursing administrators. It was apparent that these problems are basically the same the world over. There was common agreement among the nurse administrators from these countries that:

1. There is a shortage of nursing personnel at all levels.
2. Nursing personnel are not distributed in the field in accordance with health needs. It is difficult to recruit nurses for rural areas.
3. Salaries are inadequate and do not attract men and women to the profession.
4. Many nurses must accept administrative, supervisory and teaching positions without sufficient preparation.
5. There are conflicts between service needs and educational objectives for students.
6. Relationships between hospital and public health nursing services need to be strengthened.
7. Nurses are still performing domestic and housekeeping tasks.
8. Nurses themselves sometimes defeat attempts at relieving them of non-nursing tasks because they like to do what they have always done.

At least some of these are problems that are frequently discussed in Canada. Action has been taken on many of them.

For most of the first three months of this year I travelled in several countries bordering on the West Coast of Africa — from Dakar in French West Africa to Leopoldville in the Belgian Congo. I observed these same problems. It would be difficult for you to believe the acuteness of some of them — for example, supply. A political division of one country with nearly 18,000,000 people had less than 1,000 nurses. Most of these were male nurses. There were "schools of nursing" with no qualified teacher, with the students giving almost all of the nursing service. Nurses were doing more housekeeping than nursing care. But the most striking aspects were the differences or the conditions which make nursing *seem* different from what you in the Western and so-called economically developed countries consider it.

To illustrate — one of my first visits was to a maternal and child health centre. I wish I could describe the picturesque costumes and headdress of the mothers. Each one had her "pickin" securely tied to the small of her back with a fold of the cloth she wrapped around her as a skirt. Some of the mothers had walked as far as seven miles to the centre. Some arrived early in the morning — one or two hours before the centre opened. These are not the well-regulated clinics where mothers come on appointment with well babies only. One sees malnutrition, dysenteries, bronchial conditions, conjunctivitis. I saw one mother with her four-day-old baby — as yet a well baby. They waited with infinite patience squatting outside on the ground and inside in the corridors. Each one clutched an empty bottle because one of the attractions of the clinic is the "Western medicine" with which they leave.

They, as all mothers, are interested when the baby is weighed. They are glad of the all too brief word from the attendant. How can it be other than brief when over 100 mothers are to be seen in three or four hours. Perhaps the attendant may be a European-trained public health nurse, perhaps a midwife, but all too frequently a worker with inadequate training. One must not forget also that the clinic is a social meeting — a little weekly respite from hard labor in the fields.

It is almost the same picture in the prenatal clinics. There are relatively few maternity beds. Many mothers

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Miss Creelman is chief of the Nursing Section WHO, Geneva. This address was delivered at the CNA General Meeting.

who come regularly to the prenatal clinics are delivered at home or as they say in Africa "in the bush." This indicates another difference. Midwives and not doctors are responsible for normal deliveries. This is a contrast to the situation in Canada. But the tragedy is that anywhere from 50-90 per cent of the babies are born without a midwife who has had any training. In one city I was told that 57 per cent of the newborn deaths are due to tetanus neonatorum.

A high proportion of maternity beds are occupied by abnormal cases. Sometimes they are post-delivery cases who have been attended by an indigenous midwife who has interfered with the normal process of labor, or who has introduced infection. Many patients are expectant mothers far from term who have severe anemia. Some may have a hemoglobin as low as 3 Gm. per cent (14.5 Gm. per cent is normal).

In cities an attempt is made to admit a higher proportion of normal deliveries. The result is that labor rooms may have 6-8 beds and mothers are allowed to stay only 24 hours. Two mothers may have to share one bed. Rarely does one see a separate nursery. The babies are near the mothers, in cribs hanging at the foot of the bed to save space, or in a cot beside the bed. On the occasions when there is a separate nursery it is usually an imposed Western idea of what the Westerners think is better.

The first patient I saw in the first hospital I visited was an adolescent boy with trypanosomiasis (sleeping sickness) — a dread disease in some African countries caused by the bite of the tsetse fly. As we walked down the ward we saw patients with yaws, malaria especially severe in children under five years) and malnutrition. Such severe cases of malnutrition are not seen on the American continent. One form frequently seen in Africa is *kwashiorkor*, caused by a severe lack of protein. A fundamental factor in its occurence may be the sudden rejection of the child by the mother on the birth of a sibling. It is really a physical rejection from the closeness of clinging to the mother's back all day long.

There are many other cases of less dramatic malnutrition that may be caused by poverty. How can you convince a mother to give a child an egg even once a week when one egg may buy the daily rice for the whole family? The local foods such as cassava and yam are cheap and filling but they do not meet nutritional needs. Another cause may be ignorance and superstition. Eggs or milk may not be acceptable because of tribal beliefs. Dr. Trent in "Food Taboos in East Africa*" states that "The pregnant East African girl may not eat eggs. If she were to do so the baby would be bald like an egg, or might develop a large spleen. She may not drink milk because it would spoil her own milk or it would cause the child to be covered with a white coating (possibly vernix caseosa) which is thought to increase difficulties at birth or cause constipation in the newborn." And so the milk of the thousands of well-fed goats is used only by the goats' kids — which are numerous.

Pediatric wards — when there are separate wards — are always interesting. Even though the many desperately ill children are sad to see, there is a lesson for us who come from the Western countries. The mother is there with the child. Sometimes the mother and child share one bed. Sometimes there is a cubicle that contains a bed for the mother and a cot for her child. Sometimes there is a "mammy house" in the hospital compound where the mother sleeps at night. I saw one new hospital — a very modern western-style building where there was no provision for the mothers and no admittance except during visiting hours. This hospital also had a separate nursery for babies. But in chatting with the public health nurse she told me that sometimes when they find a very ill child at a rural clinic and they are able to persuade the mother to get into a car and go to this hospital — she will leave the car at the first opportunity and take to the bush. The child is never seen again at the clinic.

I hope this has given you a picture, even if somewhat blurred, of the situation in many parts of the world. Above all else it emphasizes the great need for nurses and midwives — in greater numbers and with better preparation.

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*The Lancet, Oct. 2nd, 1954, p. 703-705

Why are these workers so lacking now? There are many reasons — each one closely linked to the other and all make up the total picture. First, there is lack of education. In two countries only about 3 per cent of schoolage children attend school. Very few of these are girls. Coupled with this of course is a shortage of teachers and teaching facilities.

In an African culture if the woman does not marry and have children she is considered almost as a social outcast. Marriages are usually arranged early. There is therefore no time or desire to prepare for any other occupation or profession. This is true also but perhaps to a lesser extent, in many other countries. Polygamy is practised — the man's status is greater if he can afford more than one wife. I must tell you of a visit to one prenatal clinic. It was called a "purdah clinic" because in that country most of the women are in purdah. It was held at night, after dark, so the women could go out but not be so readily seen. I was waiting with the matron in a nearby office. A young, handsome man dressed in very colorful native costume asked for directions to the clinic saying "I have brought my two wives." And there they were!

In many cultures it is not acceptable for educated people to work with their hands. Such work is not dignified. Therefore teaching, social work, law — all are more attractive to the educated girl than nursing. Further, service to individuals outside one's own family is not a part of the general philosophy. This is one reason why it is so difficult to develop the "spirit of service" which is the very basis of nursing.

Money may be the root of all evils, but lack of money is certainly one cause for much suffering and ill-health in the world. Money is essential for teaching staff, for supervision, for the extension of services. The countries where the greatest needs exist have the least ready money. At the moment health does not seem to be high on the lengthy priority list.

It is hard to convince government authorities that money is essential if an adequate nursing service is to be provided. It is difficult because they have no experience on which to judge an "adequate nursing service." The potential of the nurses' and midwives' contributions not only in caring for the sick but in preventive work is not realized or understood. The doctor cannot appreciate the value of the nurse's observations if she never records them or is not encouraged to give them. He cannot appreciate what "nursing care" would mean to his patient if he has not seen good care demonstrated.

This may appear somewhat negative. There *is* a bright side — a very bright one — and a challenge. Conditions in such countries are changing very rapidly. We sometimes refer to them as "fast-developing" rather than "economically under-developed" countries.

What are the positive factors? First, they do not have as many nursing traditions to break down as we in the Western countries. They can start fresh and given some help they will develop something very practical, adapted to their needs. I believe that we have not always given the best type of assistance. Too frequently we of the West have retained our own ideas, based on our own culture and experience, and traditions. I suspect this is why one sees various patterns of nursing in adjacent and apparently similar countries. For example in British countries, nurse training requires 3-4 years, followed by midwifery training. In countries having a French influence the pattern is similar to that in the home country. Where Canadians or Americans have developed schools of nursing one usually finds maternity or obstetrical nursing in the basic course and no midwifery. I would not in any way wish to criticize the contributions made. They have been magnificent. But I do suggest that we may have had a greater tendency to promote "adoption" rather than "adaptation."

Another encouraging fact is the demand for education. New schools are being constructed daily. Even without buildings education is taking place. I remember a school where eight classes were held indoors and another eight classes, with teachers, carried on outdoors. This demand for education is at the same time a competition and a challenge to nursing. Extension of education necessitates more teachers.

Teacher-training institutions are attracting the educated man and woman. Educational authorities seem to have realized the necessity of providing supervised residential or hostel accommodation for the girls.

Lack of recruits for nursing, or the availability only of applicants with much less education, was nearly always, in my observation, associated with lack of accommodation for nursing students. This lack is one of the greatest hindrances to the development of nursing in many countries. Further, teacher-training institutions provide a program that is sound educationally. In countries where there is a desire for further education, this is a recognised necessity. A school of nursing which is nearly always created because the hospital needs hands, is not going to attract and satisfy those who desire further knowledge.

It is encouraging also to see the demand for health services. The people — of the bush as well as of the towns — will see to it that in time their demands are met. In Western countries, for some unfortunate reason, we have separated cure and prevention. Nursing in the public mind, and sometimes in the professional mind, is more frequently associated only with hospitals. But when you have hundreds of persons attending the outpatient departments, the infant welfare and prenatal clinics, you cannot separate prevention and cure. Here is a tradition that will not need to be broken down.

The interest that is developing in nursing as a dignified and worthwhile occupation is encouraging. There are many schools with insufficient applicants, but there are an increasing number of schools where a selection of students can be made. As young men become educated they seek wives who have more education. They tend to encourage their own sisters to go to school for a longer period of time. One day I was talking with a tutor in her office. A young police officer came to the door. He was enquiring about entrance qualifications to the school of nursing. Not for himself he said but "I have one small sister." Quite wisely the tutor suggested that the "small sister" should at least finish elementary school and then ask about the opportunities.

I have referred to male nurses. In some countries they are in the majority. As an increasing proportion of girls receive education, this will change. However I hope that boys will always be encouraged to enter nursing and that there will be opportunities for them to continue in the profession. Male nurses have a real contribution to make at the staff level, in administrative and in teaching positions, in hospital and in public health.

It is encouraging to find places where the standards are not so high, that they are unattainable at the moment. Programs of training are based on: 1. the needs and 2. the background of the personnel available for training. For example, the Sudan has had a famous program for the training of illiterate midwives. They recognized the need for midwives. They did not have women who would work in the villages and who could read and write. They nevertheless developed a very fine training and midwife service. The midwife has all her necessary medications but there are no labels on the bottles. She knows them by taste, smell, or color — and she never gives one without testing. In some countries, where up to 90 per cent of babies are attended at birth by untrained midwives, short courses are being given to these women. They are being taught three simple things:

Cleanliness — to wash their hands and boil the scissors and cord tie.

Not to interfere.

To recognize when they require assistance.

When I first joined WHO, with my limited experience, I was rather sceptical of such training. My attitude was "a little knowledge is a dangerous thing." And then one day I read about a series of demonstrations and talks (only for one week) given to indigenous midwives in China. Each one returned to her remote village. A trained nurse-midwife was able to visit them from time to time and was on call for emergencies. One night she received a call to go to a village several hours distant — the midwife needed help. When she finally arrived, the baby was born, the cord dressed, and the mother had been given care. It appeared that a good clean technique had been followed. This midwife was one who had

attended the course. She was illiterate but she had a friend who had written down notes for her. Each week, on her return to her village, she had taken these notes to another friend who read them to her. She had learned the three principles.

For a Canadian audience it may seem that I have give much emphasis to midwifery. For most countries of the world, or perhaps I should say for the most populated areas of the world, midwifery can be the basis of public health, and of public health nursing. Often the midwife is the only health worker.

Countries which have not previously had any organized program of nursing education are establishing schools of nursing. Some are requesting assistance for this. It is recognized that the teaching on the wards is most important. So even before accepting students, time is taken to help improve the service that is given in the existing hospitals. From the beginning there will be a close relationship between theory and clinical practice — a most vital element in nursing education. In Western countries we may have lost this factor and to some extent are having to struggle to regain it.

Was it not Sir William Osler who introduced this relationship in medical education? He hated to prepare lectures and said that he could not teach without a patient for a text anyway. "To study the phenomena of disease without books is to sail an uncharted sea but to study books without patients is not to go to sea at all!"

We have put much emphasis on the number of hours of lectures and the number of weeks spent in the various services. Have we given sufficient attention to determining the educational value of the clinical practice? Are we teaching principles rather than an accumulation of facts? Are we developing the ability to think and to solve problems? Are we giving enough consideration to the student as a person?

Other countries with long-established nurse training programs are looking at the content and method of their curricula and are requesting assistance to change these to meet present needs. One of the most notable changes, even though gradual in some places, is the closer link between the classroom and the clinical fields as well as the introduction of public health. I could refer to India as a country where they are experimenting with their basic programs and adding public health nurse teachers to the staff of some schools. They want to prepare a nurse who can function in public health and who is also a midwife. This represents only a few schools in a country of 350,000,000 people, but it is a beginning!

Many countries recognize the need for the young graduate to have preparation in teaching, supervision, and administration. As soon as she finishes, the shortage of professional personnel is so great, that she will most surely find herself in charge of a ward or even of a hospital. In this capacity she will not only have administrative duties but will have to teach and supervise the auxiliary workers with which her ward or hospital will be staffed. One of the most important indications of progress in nursing education is the development of post-basic schools so that nurses and midwives may obtain preparation in their own countries or in countries adjacent to and similar to their own, for teaching, administration, and public health work.

Up until four years ago if, for example, a nurse from Burma, Thailand, or Indonesia wished to qualify as a sister tutor, or midwifery tutor, or even in public health, she usually went to the United Kingdom, Australia or New Zealand and sometimes she came to Canada or to the United States. Now Burma has courses for public health nurses and for nursing educators. Thailand and Indonesia have the same. In addition Indonesia and India now offer preparation for midwifery tutors. Until three years ago a nurse in India, unless she took her complete training at one of the two nursing colleges in Delhi and Vellore, could not qualify as a public health nurse. Now there is a well established course at Calcutta.

This does not mean that nurses will not continue or need to go abroad for further education. This will always be necessary. Incidentally it should be a two-way exchange — nurses from Western countries have much to learn from the East. Now, however, they will come with a richer background of

preparation and experience. They will have a better idea of what they want to learn. This will be a challenge to the West — to give them something worthwhile, adapted to their needs and on an advanced level.

The establishment of nursing education on a university level is encouraging, but this is a development which should proceed very slowly. A university course should not be established because it is "fashionable." It must be considered in relation to the status and philosophy of education of the country.

Most encouraging of all is the fact that nurses themselves are awakening to the nature of their responsibility for the development of the profession and the provision of a good quality of nursing service. In too many countries nurses have been content to follow. Now they are moving into leadership. Those of you who were in Rome last year saw this demonstrated and must have experienced the thrill which the receiving into membership of ten new countries gave. If only you could know the work which led up to that event for each new association!

To return to the point from which I started — nursing is the same the world over. It is the conditions under which and for which nursing care is given and to which it must adapt that differ.

I will close by telling you of an experience I had one Sunday morning in March in Ibadan, Nigeria. In that city of nearly 500,000 people there is a beautiful new University College Hospital and a new school of nursing associated with it. This school has a standard which gives the graduate reciprocity with the United Kingdom — that is, she is given the S.R.N. However, the S.R.N. syllabus as laid down by the U.K. has been adapted to the needs of Nigeria. Among other interesting features it contains a block of two months for "community nursing."

I accompanied two students on their rounds that Sunday morning. We went first to a young girl with a discharging TB. hip. I wish I could adequately describe to you that primitive home in its African compound, and the preparations which they had taught the mother to make for each visit. They had even taught the patient to sew and make clothing for her young brothers and sisters. Our next call was to an elderly lady with advanced carcinoma of the face. She was too weak to make the necessary trips to the outpatient department and the dressing was too complicated to teach the daughter in whose home she lived. The gratitude of that mother and daughter well repaid the students for the hot dusty walk to the mud house. This was purely and simply the alleviation of suffering. Then we visited premature twins. The students gave their mother advice regarding their feeding and care.

And so the morning passed. I thought much about this experience. It occurred to me that I had seen demonstrated the very essence of nursing — which must be the same the world over and which requires all our efforts to bring to its full achievement — the alleviation of suffering, rehabilitation and the teaching of health.

The health of the eyes is directly related to the general health. Infected teeth or sinus may cause damage to the eyes; eye troubles may affect the digestion. It is important to wear properly prescribed glasses when these are necessary.

—Dept. of National Health & Welfare

* * *

In a case of sunstroke, the patient should be kept in a cool shady place. Wrapping him in a damp sheet will help to lower his temperature. He may be given drinks of cold water if he is conscious. He should have medical aid or be taken to hospital.

—Dept. of National Health & Welfare

Toys are the universal tools that help children grow. By playing, exploring, and performing with toys, children develop and perfect their physical skills. This is true for both normal and handicapped children. Toys encourage a healthy infant, as well as a three-year-old with weak arms to reach. But even though both children are in the same stage of development (learning to reach but unable yet to grasp), the infant and the three-year-old have widely different interests. This means that toys should be selected to fit hand and arm developments as well as the interest level of the individual child.

—Mrs. June Frantzen

Nursing and the National Health Program

J. Waldo Monteith

It is perhaps fitting that the greetings of my Department should be conveyed at the session in which you will be dealing with the important and timely subject of mental health. The Dominion Government has a keen interest in this area. One of its largest grants under the National Health Program has been set aside to foster provincial activities in this regard. In the last 10 years federal funds have helped with the specialized training of over 1,500 psychiatrists and other mental health personnel; have assisted with the establishment of some 140 community mental health centres; and have stimulated no less than 130 research projects. In addition, monies under the Hospital Construction Grant have been contributed towards the provision of more than 17,000 additional hospital beds for the mentally ill.

While mental illness unfortunately, is still increasing in Canada, there have been a number of recent encouraging developments. Dynamic programs of therapy are becoming more common at the hospital and community level. More money is being made available from various sources (including federal funds) for research as well as for treatment. Attention is being focused on new types of mental hospital construction. Citizen interest in preventive measures appears to be definitely on the upswing. Moreover, there are indications that psychiatric nursing is attracting increasing numbers of well-qualified nurses. Indeed, in a sense, psychiatric nursing seems to be moving into a leadership role where it may, in time, influence the standards of the whole profession. The federal health authorities welcome this Association's mounting concern for the problem of mental illness. They are confident that nursing can make a unique contribution to progress in this field.

To my mind, the participation of Canadian nurses in international health programs is one of the noteworthy signs of the maturity achieved by their national association during the past 50 years. Its growth has paralleled the development of Canada. Your organization has shared the shocks, strains and exhilarations involved in our rapid advance to responsible nationhood. It has felt the impact of the vast technological revolution that has gone on about us since the turn of the century. But throughout all this, nursing has maintained its balance — has kept its feet on the ground, so to speak — and has never wavered from the high ideals of public service to which it was dedicated by its founders.

Your first half-century has been marked by the courage of many outstanding leaders — women of vision and perseverance — as well as by the faithfulness of you rank and file. The profession has experienced many trials and anxieties. Among other things, it has had to meet heavy and complex responsibilities not only to patients but also to doctors and the public at large. It is surely a tribute to your good sense and versatility that despite the increasing demands made upon you from so many quarters, the quality of your service has remained unimpaired.

Like practically everything else in modern society, nursing is in a state of transition. This means that you continue to have problems. While I am no expert in your field of endeavor, I am aware of a number of matters with which you are currently grappling:

How to make the most effective use of nursing skills, having regard for the increasingly heavy demands for these services.

How to integrate successfully the various members of the nursing team.

How best to reconcile the conflicting claims of nursing service and nursing education.

How to establish closer cooperation between nursing and other health professions.

How to increase public awareness of various nursing problems that cannot be fully mastered without its support.

The Hon. J. Waldo Monteith is the Minister of National Health and Welfare. He delivered this address at a general session during the CNA Convention.

I can assure you of the wholehearted support of the Department of National Health and Welfare. We have greatly appreciated the cordial relationships that have developed over the years with the Canadian Nurses' Association. We look forward to extending and deepening our areas of mutual understanding and cooperation. All public health programs are, in large measure, dependent on nurses. No organization could be more fully aware of this than my Department.

No doubt the most important area of our joint interest in the immediate future will be the new Hospital Insurance Program. This scheme will involve — either directly or indirectly — almost everyone concerned with Canadian health activities. While its impact is likely to be most noticeable upon hospitals, the medical profession and individual citizens, nursing will also feel its effects to a considerable extent.

A basic fact to keep in mind is that the scheme does not represent a single over-all national project. In line with our constitutional setup, it embodies a series of provincially administered plans supported by financial and technical assistance from the Dominion Government. For its part, the Federal legislation simply lays down a broad framework within which provincial plans must be fitted although provision is made for a good deal of variation to take care of local needs and traditions. In other words, while no two provincial programs are likely to be identical in every respect, a good measure of uniformity will be maintained across the country. That is the first point to be stressed.

Another factor is the scope of the services that the scheme will provide. As its name implies, this is a hospital care program. It will cover standard hospital ward services together with essential laboratory and radiological procedures. It will not enter the field of medical care, nor will it interfere with the traditional patient-doctor relationship. There are certain basic inpatient services that are mandatory for all provincial plans, while a number of outpatient services may be included if the provinces so desire.

With regard to financing, the costs — which are estimated at some $300 million annually at the outset — will be split on a roughly 50-50 basis by the two senior levels of government. The federal share will come out of the Consolidated Revenue Fund, while that of the provinces will probably be derived from general tax revenues, premiums or special sales taxes. This raises another crucial point that should not be overlooked in considering the scheme.

This is not in any sense a free care program. Like other health services, it will have to be paid for by those whom it is designed to benefit. The people of Canada will contribute towards its operation through their federal income taxes and also perhaps — depending on the province in which they live — through the payment of other levies. What the scheme is designed to do is simply, by means of prepaid insurance, to guarantee to every resident of this country his basic hospital needs at a price that is within his economic capacity. Experience has shown that only a public plan can spread the costs of hospital care over a sufficiently wide area to achieve this objective.

On July 1st of this year federal funds were made available to any province that had signed an agreement with the Dominion Government and had a plan of its own in operation. Initially, five provinces — British Columbia, Alberta, Saskatchewan, Manitoba and Newfoundland — are expected to participate. Four others hope to come in by the first of next year or shortly thereafter.

In view of the scheme's imminence, you can imagine how busy we, in the Department of National Health and Welfare, have been with last-minute preparations. It is no simple task to achieve agreement among so many different governments on a matter of such complexity. Looking back over our efforts in this connection, I cannot help thinking of the recipe which an American public health expert has put forward for bringing an undertaking of this kind into being. Here are the ingredients that he cited as essential:

> Remove all fat from the project
> Soak overnight in prudence to remove excess salt
> Rinse repeatedly in honesty

Place in baking dish buttered with integrity
Season with a tablespoon of optimism
Add two cups of enthusiasm
Cook thoroughly with perseverance
Serve steaming hot with or without a sprinkling of concession.

It would certainly seem that this man knew what he was talking about.

Turning now to the program's impact on your profession, the over-all effect should be distinctly favorable. As you are no doubt aware, "necessary nursing service" is one of the mandatory items that *must* be provided to inpatients, and that may be extended to outpatients if provincial plans so specify. It would appear that nurses are unlikely to have an employment problem in the foreseeable future.

Nursing cannot help but benefit from the fact that hospitals will be in a much sounder financial position. By assuring these institutions of their basic operating costs, the scheme will relieve them of the mounting deficits that they have been experiencing in recent years. This should enable hospitals to develop even higher standards of care than have previously been possible. They should be able to arrange their services so that nurses and other members of the staff can make a more effective contribution of their skills. The legitimate needs of your profession — both as to quality and quantity — may now be considered by hospitals on the basis of individual merit without regard to operating debt.

I am aware that concern has been expressed in nursing circles over the possibility that you may be faced with excessive demands as a result of the hospital insurance plan. I am convinced that this will not be the case. As evidence, I would point out that before the Dominion Government enters into an agreement with any province, the latter is required to have formulated methods for the control of hospital utilization. Considerable responsibility in this regard will rest with hospital officials and doctors. Through their active cooperation suitable arrangements can be worked out whereby the quality of hospital care may not only be maintained but even raised above its present standards.

To digress for a moment, I would emphasize that no one involved in the hospital insurance program at any level maintains that it is perfect in every respect. No doubt adjustments will have to be made in some of its provisions. As far as federal authorities are concerned, however, our overall policy has been to get the scheme as it now stands under way as soon as possible and to postpone major changes until experience has been gained in its operation.

It has also come to my attention that some members of your profession are not entirely happy about the inclusion of nursing education as a part of the operating costs of hospitals. In following this procedure we are going along with current hospital practices. Indeed, this policy is one of the primary principles underlying the whole insurance program. Frankly, I do not see how it could be otherwise in view of the constitutional role of governments in this undertaking. Much the same sort of thing has been said to the medical profession with respect to some of their problems. This is not an expression of opinion as to the merits of the case. I am merely saying that I do not feel that the hospital insurance program should be expected to change the *status quo* in this regard.

I have referred to the fact that provincial schemes must include arrangements for guarding against the improper use of hospital facilities. I have indicated, too, that the basic responsibility in this area will rest with hospital officials and the medical profession. It is they who will have to establish rules and regulations governing such things as admission and length of stay. A further point to make in this connection is that whatever controls may be instituted will not be truly effective unless they are understood and supported by the general public. Here is where nurses can make a vital contribution. If there is any group in the community that can help educate their fellow citizens along these lines more effectively than another, it is surely the members of your profession.

You are looked upon with respect and confidence and have wider contact with people than any other member of the health team. Accordingly, you are in a unique position to preach responsibility in this matter, to get across to your neighbors how necessary it is

for them to use restraint and commonsense in demanding hospital care. The pressure on doctors and hospitals may well be heavy. It is important for you, as nurses, to support them in saying "no" to the irresponsible use of these important health facilities.

The hospital insurance program is probably the most ambitious project ever undertaken in the health field in Canada. The more I study its implications, the more I am convinced of the importance of cooperation to its success. The scheme is so complex, involves so many agencies and individuals, that only through a strong willingness on all sides to work together can it possibly achieve its goal. We are generally agreed that it will be a good thing for the nation. Let us then resolve together to do our utmost in developing it to the full extent of its potentialities. This is a challenge I would present to all Canadian citizens and particularly to the Canadian Nurses' Association on this momentous occasion.

Back in 1908, one of Canada's nursing pioneers called on your profession to use its larger opportunities for making this country and the world "better and brighter and purer each succeeding year." This you have surely done. Today, five decades later, your theme is "Into the future, open a better way." The words are different but the objective is essentially the same. In the half-century ahead, may you find the strength and courage to fulfill this ideal even more completely than in the past. Such is my wish for you on this historic anniversary.

Research has shown that Krypton 85, a radioactive form of a harmless inert gas, can be used to detect abnormal openings in the wall of muscle dividing the right and left chambers of the heart. Left to right "shunts" of blood which result from defects in the partitions of the heart are the commonest form of congenital heart disease. Accurate knowledge of the presence and location of these defects is essential for corrective surgery.

The choice of Krypton 85 is based on its complete inertness and ready availability. In addition, 99 per cent of Krypton 85's radiation is non-penetrating, making elaborate precautions for its use unnecessary, even for medical workers who are repeatedly exposed.

Krypton 85 can be measured instantly and accurately with an instrument similar to a Geiger counter after the gas has been introduced into one side of the heart and some of it has been recovered from the other. This makes the test simpler than any previous laboratory techniques. It is more accurate than the standard techniques now being used in most heart clinics. More than 100 patients with proved forms of heart disease have been studied, and Krypton 85 has made possible the correct diagnosis in every instance.

In developing the technique, dogs with heart defects were used. Radioactive Krypton was introduced into the left side of the heart by having the dogs breathe it, mixed with air, from an ordinary rubber anesthesia bag. The radioactive gas was instantly picked up by the bloodstream from the lungs and carried to the left side of the heart, along with normally oxygenated blood destined to supply the dog's whole body. In a perfect heart, this blood does not enter the right side of the heart until it has completed the circuit through the arteries to the body. It returns through the veins into the right side of the heart ready to be sent, from the right side, to the lungs for a new oxygen supply.

In the experimental animals, the normally high pressure in the left side of the heart forced the blood not only into the artery leading to the rest of the body, but also through the holes in the partition between the left side of the heart and the right. This robbed the dog's body of part of its needed blood supply. This is what happens in a human being with a congenital heart defect in which the blood is shunted from left to right.

Using the technique of catheterization, with the experimental animals, a length of tiny plastic hose was threaded through a neck vein feeding into the right side of the heart. Through this tube, blood could be drawn directly from the right side. In a normal dog breathing radioactive Krypton, samples of blood showed very little radioactivity — the radioactive gas had been largely dissipated on the long journey of the blood around the body.

When blood from the hearts of the dogs with heart defects was tested however, it was found much more radioactive. This showed the presence of the defects. By "aiming" the tip of the catheter at different parts of the heart, the location of the defect can be determined. Many heart defects involving left-to-right shunts can now be repaired by surgery.

— U.S. Dept. of Health, Education and Welfare.

The Nursing Profession and Social Change

AILEEN D. ROSS, PH.D.

A SHORT TIME AGO a nurse told me that "nurses are a restless, unhappy lot." This is not a surprising statement to a sociologist, for he would consider people almost queer if they were not restless and, at least sometimes, unhappy in the confused world in which we live.

This paper will discuss a few of the major problems that are causing dissatisfaction in the nursing profession. First, it will deal with some of the changes occurring in the world outside the hospital which are affecting the nurse's position and her self-conception. Then it will go on to discuss the way in which these changes affect hospital training, and how the training in its turn, influences the off-duty time of the nurse.

As our society is one in which continuous and rapid social change is causing many new technological innovations, the well-worn term "insecurity" is an appropriate word to describe the general feelings of all people in important positions in our major institutions today. For the new forces have been instrumental in not only changing the outward behavior of people, but have also altered the conceptions of how many traditional roles should be played. Thus the nurse is now not only up against revolutionary changes in nursing techniques and constant new organization of an increasingly specialized hospital personnel, but she must also face a radical change in her self-conception of herself as a nurse. Moreover, it seems that this changing self-conception does not jibe with the slower changing ideas doctors have of nurses, nor with the even more leisurely change in the public's expectations of how a nurse should behave. So even if a nurse was able to work out a clear picture of her present position for herself she would be constantly confused by the lamentations of patients, doctors and the public in general who prefer the nurse of the past.

A quotation from a nurse's essay illustrates this confusion:

> Nurses now consider themselves professionals, yet the professional person is supposed to have initiative and be self-propelled. But nurses are still trained in more or less autocratic types of institutions, where the authority of the other departments and the nurses ahead allows them little initiative.
>
> Moreover, as the doctor's handmaiden, she often must crush dynamic aspects of personality and creativeness. As for the public, many of them still think of the nurse as an ideal of self-sacrifice, gentleness and kindness, devoted to duty and pure of mind — a replica of Florence Nightingale!

This uncertainty of the nurses' self-conception often causes them to believe that the seeming failure of the nursing profession to run smoothly and efficiently lies mainly within itself, rather than seeing its performance in the more general perspective of the dilemmas of a changing society. Let me illustrate this point by outlining a few changes which have definitely affected the nursing career.

First, I will refer to the prestige of the nursing profession. Nursing is no exception to the general rule that the prestige of occupations varies from country to country and from one period of time to another. When nursing first became a firmly established profession on this continent it was one of the few jobs for women which had enough prestige to entice even women from the so-called best families. Only marriage, motherhood and, possibly, becoming a nun ranked higher in the public's esti-

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Dr. Ross is on the faculty of the Department of Sociology and Anthropology, McGill University, Montreal. This paper was read at a meeting of the Association of Nurses of the Province of Quebec. It is based on material taken from term papers written by nurses over a period of 10 years for an introductory course in sociology. Fuller elaboration of these ideas and others pertaining to the nursing profession will later be published in book form.

mation. The prestige of nursing was also high because the medical profession then had a monopoly over the knowledge and skills of healing. There were few commercial medical advertisements or willing chemists with their dazzling array of tantalizing cures, to lure the unhappy victim.

Today, a gradually changing economy from agriculture to industry has caused a revolutionary change in the position of women so that it is now a practical necessity, and I suspect is becoming a psychological and perhaps even a "moral" necessity, for women of all classes to do some kind of work at least up to marriage, and often after.

Once well out into the work world and with the opportunity to acquire an education equal to men, women responded to the general atmosphere of a "climbing" society. We now find them in many types of occupations, some demanding the prestige symbol of a university degree. This movement has introduced us to the career woman — a term which has nearly replaced that of spinster which in the past referred to a woman who, having failed to get a husband, returned to a dreary dependent life, at the beck and call of brothers and sisters who needed unpaid baby-sitters. Thus women have gradually been able to get into many jobs which are rewarding psychologically as well as financially, and which have acquired glamor in the eyes of at least their fellow sisters. So we have female business executives, radio and TV stars, journalists, quiz program experts, lawyers, doctors and even professors.

Many of these positions, on the surface at least, look more attractive than caring for sick people, and appear to give more freedom and better pay. This factor of income is not to be underestimated in a world in which one's worth in the eyes of the public is often mainly accounted for by the size of one's salary. Money determines the "conspicuous consumption" in terms of residence, travel, dress and recreation which Veblen pointed out as being of major importance in ranking a person in our society. Inadequate remuneration, too, may produce many fears about future financial security, especially on retirement.

Even the prestige of marriage and motherhood often pales in comparison with the independence and excitement of having a job in which one may display initiative and get public recognition. A career woman in the United States, where changes usually occur more rapidly than here, recently commented that married women would often tell her they were doing "nothing," when in reality they might be looking after a husband and five children. It is to be surmised from our knowledge of the problems of a mother today, that what "nothing" referred to was not work, but rather that nothing seemed worth while mentioning in comparison to the life of my career friend. This idea of the gradual decline in prestige of the housewife role is supported by many studies which show that married women often claim that housework gives them no feeling whatever of being useful or important. On the other hand, the large proportion of working women claim that their jobs give them a sense of worth.

These remarks can be summed up as proof that nursing has now to compete with a whole series of new work roles for women, many of which seem to be more exciting, *are* more lucrative, and may involve less hard work and shorter hours than those of the nursing profession.

As the prestige of an occupation changes so does the self-conception of those in that occupation. It is easier to remain content with one's lot if there are no competing attractions, and certainly in this respect the nurse is no longer sure that her profession is as highly thought of by the public as it was in the past.

Another radical change which has taken place is related to the qualities desired in a nurse. Formerly these coincided with the so-called "feminine" qualities, such as patience, gentleness, compassion, and submission to those in authority. That is, the role of a nurse was essentially a woman's role. As her training for her feminine position began at birth, the essential character of her role was well laid down when she entered a school of nursing. All that remained to be done was to add the skills of nursing.

Today our idea of womanhood has radically altered. Although it too is in

such a confused state that it is difficult to see our expectations of it clearly, we do know that equality of education, more freedom to move outside the home, and the competitive spirit engendered by examinations, sports and youth organizations are all producing a quite different feminine personality than in the days of Florence Nightingale. A woman *cannot* win the skiing championship of the world, swim the English channel, become a parachute jumper or an executive in a large business concern without portraying more initiative and aggressiveness than was typical of the former submissive wife.

What do these changes, and many others that cannot be mentioned here, mean in terms of training to become a nurse today? At this point I would like to pause to consider this problem from the point of view of the hospital. In our day of large-scale organization, many institutions find that they must develop bureaucratic types of organization to deal with the infinite number of details that are faced when literally hundreds of workers must be geared to a single purpose. Thus all large-scale business corporations and governmental institutions, as well as hospitals, must train many of their workers to fit more or less automatically into the whole organizational scheme. This means strict rules of procedure, and a stifling of initiative in the lower ranks. For the major decisions can only be initiated at the top.

The only way in which the hospital differs from other organizations of this type is that since its main function is to deal with matters of life and death, it can afford even less deviation. Initiative, taken by a partly-trained member of the staff, might end in tragedy. The chief job of the hospital then, is to train its recruits to fit into its strict routine as perfectly as do the parts of a well-oiled machine.

This task was easier in the days when student nurses came mainly from the same ethnic and religious backgrounds. Today, in Canada, hospitals are presented with recruits who come from many countries and faiths, all brought up on slightly different interpretations of Canadian folkways and mores.

Another problem in the training of nurses is that, as the family structure has been gradually changing, potential hospital recruits are brought up under much more democratic systems of discipline than in the days when "father definitely knew best" in the eyes of the family. In other words, the strict authority of the former large, extended family is now being replaced by one in which children are being raised to take responsibility for their own actions at an early age. When these products arrive at the school of nursing they are not prepared, as were former recruits, to face the strict discipline which the hospital demands. It is perhaps unnecessary to emphasize that this is often the hardest part of the preliminary student's training. She has to face what to her seem completely unreasonable rules without being allowed to "reason why" or told why such rules are necessary. Hospital discipline is often mentioned by these youthful students as being dictatorial or likened to a military regime. They often refer to themselves as "slaves."

The symbolism of the uniform reinforces their lowly position at the bottom of the hospital hierarchy. This was described in a telling way by a student who overheard two women discussing a procession of nurses, headed by the matron and top nurses in their shining white, and ending with the "probies."

> As the matron and head nurses appeared one of the women said to the other "My dear, aren't they lovely. They certainly do look like angels!" But when the probies finally paraded past she said "My word! Those must be the cooks!"
>
> After that we were always known as the "cook" class. If we had retained any feeling of pride in ourselves before that incident it was thoroughly shattered by the woman's remark.

Let us now look at the problem of training as a whole. Anthropologists tell us that traditional patterns of behavior are much more effectively passed on to growing children if parents, relatives and the community all agree about the type of adult they want the child to turn into. If this is so, and adults do not think of children as having unique personalities which must be individually fostered to maturation, they will all treat them in a

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similar-enough way that the children will be given a clear, definite picture of what they should be like. This type of training is found is societies where there is relatively little change, so that the same kind of behavior can be passed down from generation to generation. In such cases the child is reared, one might say, almost automatically to become the "living spit" of his parents. Moreover, the models for his adult behavior are close at hand, for he is in constant, intimate contact with the older people he is to emulate. In this way the child consciously and unconsciously copies their behavior until it becomes an integral part of his own personality.

Ruth Benedict[1] has called such training "continuous" in the sense that there are no sudden disruptions in the process, and no unexpected new behavior is expected of the child when he becomes adult. Many anthropologists claim that such societies have a minimum of personal insecurity and disorganization.

The success of the army in producing soldiers who respond to the same stimuli, more or less as conditioned reflexes; the success of the monastery in developing monks who follow the traditional ways almost automatically; and the success of hospitals in the past in producing generation after generation of nurses so identical that the public could evolve a rigid stereotype of them, can be seen from the anthropologist's point of view to reside in the fact that in each case the institution was able to isolate its recruits in tradition-bound institutions, whose training worked very much in the same way as socialization in traditional societies.

Now, however, changing conditions are constantly causing alterations in hospital organization. The recent great leaps in medical knowledge, promoting in their wake the need for more varied care of the sick, has meant that hospitals are constantly being reorganized to bring in more and more specialists. Thus, the nurse must now relate herself to an ever-increasing army of technicians, as well as to such new classes of people as physical and occupational therapists and social workers. New conceptions, too, are arising as to who should train the student nurse. Nursing instructors are invading the former sanctum of the head nurse and rival her monopoly of control. In fact, so many experiments are going on that no one in the hospital is really sure — except perhaps the old guard who cling to the dimming vision of Florence Nightingale — just what they want the new student to do, or be like.

The training of the student nurse today could, therefore, in the words of Ruth Benedict, be called "discontinuous." It is discontinuous in the sense that it is not a clearly patterned progression — difficult perhaps, often unpleasant, but always sure — to some clearly defined eminence at the top of the nursing hierarchy.

This, of course, does not suggest that experiments in training are wrong because they are upsetting. It is the very nature of our society that we must experiment, and in times of rapid change probably the more experimenting the better. But it does emphasize the point that the training of the nurse today is *quite* a different matter from that of former times.

What effect does training have on the adjustment of the nurse to people outside the hospital? The cleavage between the nurse and the outside world begins when the social life of the preliminary student is gradually restricted to the company of other nurses and the residence. This is at first due to the fact that she has little time or energy after the day's work for previous habits of relaxation, such as music or sport. Some say they even find it difficult to attend church. So outside invitations are declined until even former best friends are discouraged, and no longer invite. This means that students almost invariably become slowly isolated from former friends. This in turn means that there is soon almost "complete cessation of outside activities." And then, inevitably, students begin to "socially live in a world of their own."

With the gradual absorption of the student into the life of the hospital, her interests no longer coincide with those of former friends or even her family. Usually, too, the vivid drama

1. Benedict, Ruth: "Continuities and Discontinuities in Cultural Conditioning." *Psychiatry*, 1938, Vol. 1, pp. 161-67.

4 New *SAUNDERS* Books and Editions To Assist the Nurse

Johnston — Personnel Program Guide For Nursing Education and Nursing Service Agencies

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By Mary W. Falconer, R.N., M.A., Instructor in Pharmacology, O'Connor Hospital School of Nursing, San Jose, California; and H. Robert Patterson, B.S., M.S., Pharm.D., Associate Professor of Bacteriology and Biology, San Jose State College and Pharmacist, O'Connor Hospital San Jose, California. 157 pages. $3.25. *New!*

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of hospital life means that the student's new emotional experiences are not matched by those of old friends. She comes to feel that she is much more mature than her outside contemporaries. So there is a slow withdrawal from outside contacts even when nurses are nominally off duty. I say "nominally," for students report that from the very beginning of their training their off duty behavior is controlled in a number of ways by the rules and regulations of the hospital. Many nurses referred to this as one of the most frustrating parts of their hospital experience, for they resented being treated as "children" in the more personal aspects of their lives. In effect the hospital tells them when to go out, when to come in, what they should wear when out, what streets and restaurants they should *not* frequent, and how they should behave in respect to such things as smoking and drinking.

However, whether frustrating and resented or not, the chief function of this system is to make the nurse carry her conception of herself as a nurse with her into her social life. Thus the axioms of nursing gradually and persistently seep into the nurse's off duty life. She constantly checks her behavior in public, even when the anonymity of the large city frees her from the watchful eye of the hospital hierarchy. This eventually means that one of the main problems of the graduate nurse in developing a satisfactory social life when she again steps out into new fields beyond the hospital, lies in the fact that her training has been so efficient in turning her into a nurse that it has encompassed all aspects of her personality. That is, it *has* been successful in its purpose.

This internalization of the nursing role until it has checked off-duty behavior was vividly portrayed in a nurse's paper which described her shock when, having moved to another Canadian city, she saw nurses acting in public in a way to which she was not accustomed.

> I was literally numbed with shock while walking through the large department store to see a nurse, complete in uniform and white shoes and stockings, cap and hospital pin, on the escalator. Later I saw nurses getting on a bus dressed in uniform. I had been too deeply trained in the importance of the uniform to treat it in this casual way. But as no lockers were provided at the hospital for nurses, I found that I too had to wear my uniform to work. So I wore my white dress and stockings, with a coat over the dress. If it was unbearably hot I opened my coat and removed my hospital pin. In this way I convinced myself that I would be taken for a beautician rather than a nurse.
>
> The final blow occurred one night when some of us went to a girl's house for coffee. Unexpectedly, friends from out-of-town came in and wanted us to see the night life of the city. I refused to go along when one of the girls decided to go with them without changing out of uniform. So she went with them while I went home alone, not wanting to be seen in the company of such a nurse.

Off duty controls also cause problems when the nurse leaves the security of her nursing group on graduation and moves out into community work. If she remains in the hospital, life there may become socially frustrating. Some nurses say they make determined efforts to pick up new interests or make friends outside their medical circle after graduation, for they feel cut off from the rest of the community. This is not always easy, for the community, too, has its stereotype of the nurse, and along with the minister and the teacher, expect behavior of her in accordance with their stereotypes even when any of these people are off duty. This may be particularly frustrating in small towns where the nurse is never out of the range of the watchful eye of the populace.

Teachers have told me that it is often a year or more before they are asked into homes even in small towns, and then usually only to the symbolic Sunday dinner, whose typical extra formality expresses the attitude of the public to those who play stereotyped roles in the community. They are seldom asked to the intimate, friendly cocktail parties. Even their purchases at local shops may be criticized, and heaven help those who encroach on the hunting preserves of the local spinsters! It is therefore no wonder that nurses often claim that the only time they relax when off duty is when

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they are able to get out of the town.

Life in a small community can thus be extremely lonely for the one or two representatives of the nursing profession who have no one with whom they can share their medical interests and problems. On the other hand, they can find few opportunities to share in the life of the community as ordinary citizens.

This paper has tried to show some of the problems faced by the nursing profession today which are likely to cause confusion, restlessness, and dissatisfaction. It has stressed as a major point the fact that no group can remain to itself alone, or plan its own progress without taking into account the influences which impinge on it from outside. In it the problems have been emphasized, but the other side of the picture shows that a changing world not only presents unpleasant dilemmas but also stimulating challenges for the reorganization of behavior.

The Patient, the Bedpan and the Nurse

AUDREY COBOURNE

MANY HILARIOUS ANECDOTES have been written by would-be authors, highlighting the horrors created in the mind of a patient experiencing his first introduction to a bedpan. This meeting need not be charged with such emotional stress if the nurse performs the procedure with the calm, understanding attitude accorded to other physiological functions of everyday living.

The average citizen is able to ensure privacy at regular intervals for the length of time required by elimination. Thus, uninterrupted, in a well-ventilated bathroom, he is able to respond to the mass wave of peristaltic action with complete relaxation and freedom from discomfort. Washing facilities for his after-care are easily accessible. He departs with the satisfaction of accomplishment, as Nature intended he should.

Now this average citizen has become a hospitalized bed patient, dependent on the nurse for such personal care. In providing for this service she should give prompt response to his request, (if she is not sufficiently well acquainted with the patient's routine to anticipate his need), complete privacy if at all possible, and as much relaxation as a comfortable position and relief of pain will allow. When the patient signals his readiness the nurse will, after assessing and disposing of the contents of the pan, provide washing facilities and the benefit of an air deodorant if the occasion demands it.

Like the White Queen of Alice in Wonderland fame, the practice of imagining impossible things appeals to me and so I present the case of the eloquent bedpan, offering its plea for prestige in the field of medicine by presenting evidence through which its contents, reported by an observant nurse or through analysis, substantiates the physician's tentative diagnosis.

Black tarry stools denote the presence of the occult blood of the bleeding duodenal ulcer; mucus and blood accompanied by a foul odor of the feces are indicative of ulcerative colitis; clay-colored stools supplemented by jaundice lay the fault on an obstructed common bile duct; presence of many parasitic infestations are revealed in the stools; "pea soup" and "rice water" are the descriptive terms applied to the typical evacuation of typhoid fever and cholera respectively; a lienteric stool usually indicates faulty mechanical digestion as the diseases of the pancreas are symptomatized by the fatty stool; the pipe stem and the ribbon shaped stool reveal a possible lower rectal stricture. Aye, and the presence

A graduate of Toronto East General Hospital, Miss Cobourne recently completed her course in hospital nursing service at the School of Nursing, University of Toronto.



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of a penny in the feces can clinch the pediatricians' diagnosis of an ingested foreign body.

In supplying further proof of the merits of the vessel under debate, the urinary system is called to the stand.

Ureterolithiasis may not be truly ascertained even with x-ray until a fragment of non-opaque calculus is strained out of the voided urine; gross hematuria speeds many a patient to early treatment of a bladder tumor; albuminuria warns the obstetrician of an impending toxemia; the medical man looks for the sign of albumin to support his diagnosis of nephritis; glucosuria plus a high estimate of the blood sugar points to the sufferer of diabetes mellitus; bile appears in the urine of the patient with obstructive jaundice. Laboratory test may prove an early pregnancy by detecting the hormone secreted by the chorionic villi and excreted in the maternal urine.

Objective symptoms such as polyuria, anuria, nocturia and frequent micturition, as reported by the observant nurse in caring for the patient's needs, constitute valuable adjuncts to diagnoses.

The subjective symptoms such as tenesmus and dysuria may be noted by the nurse if her presence is required in the patient's support while using the pan.

Character witnesses offer evidence. The edematous patient, whose progress is closely followed by the measurement of the excretions and the postoperative patient whose fluid balance is controlled in part by the measured output of the alimentary canal and the urinary system vindicate the plaintiff.

Defence rests its case on the bedpan contoured to accommodate all shapes of the enforced bed patient. It is hoped, by the presentation of the preceding facts, this instrument of service, efficiently handled by the nurse, will be allowed to take its place along with the sphygmomanometer and the stethoscope in the diagnostic and curative field of medical science.

By methods of indirect teaching the most apprehensive patient can learn to accept the contribution the bedpan offers to his prompt diagnosis and eventual recovery. A tactful manner on the part of the nurse caring for his bodily needs will allay diffidence and promote confidence in her abilities as a professional person.

The Good Old Days

Good old days? In an age when coffee breaks, the 5-day week, air conditioning and other amenities are taken for granted, it's enlightening to read the Office Rules drawn up by one employer of the 1870's:

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6. Men employees will be given an evening off each week for courting purposes, or two evenings a week if they go regularly to church.

7. After an employee has spent his hours of labor in the office, he should spend the time reading the Bible and other good books.

8. Any employee who smokes Spanish cigars, uses liquor in any form, gets shaved in a barber shop or frequents pool and public halls, will give me good reason to suspect his worth, intentions, integrity, and honesty.

9. The employee who has performed his labors faithfully and without fault for a period of five years and who has been thrifty and attentive to his religious duties will be given an increase of five cents per day, provided a just return in profit from the business permits.

— (Royal Bank *Magazine*)

It is not the oath that makes us believe the man, but the man the oath.

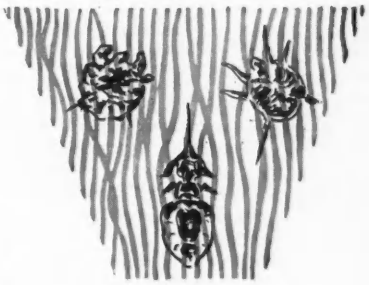
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DORIS W. PLEWES, Ed.D., F.A.C.S.M.

CONCERN FOR FITNESS is not a new thing but concepts vary concerning what it is, the need for it and how best to attain it. Throughout the centuries it has always been associated with survival. Primitive man had to learn how to care for his disabilities without interrupting his hunt for food, and flight from predatory animals. Necessity proved to be the mother of invention — he used many of the basic principles which underlie current procedures. Later, concern for wartime fitness for survival overshadowed its peacetime values. At a still later date, it was regarded as something for athletes. Today the need for the peacetime development of human energy is recognized. With sputniks, guided missiles and the like in the offing everyone must depend on his personal energies if disaster strikes.

Canadians have been slow to recognize the urgency of the need for physical efficiency. The remarkable improvements achieved by other countries are the result of long-term planning and effort. The United Kingdom has made surprising gains. Formerly their rejection rate was not very different from our own. In 1956, the call-up of 18- to 20-year-olds found over 90 per cent of them immediately fit for service — 76 per cent of them in top category. Western Germany found 80 per cent of her call-up ready for service. These figures compare with approximately 60 per cent plus in the U.S.A.

Official medical and administrative reports concerning troops used in Korea show that unwounded North Americans possessed inferior stamina and endurance to wounded nationals of other countries. This makes us wonder if vigorous physical training, postponed until adolescence, can ever be more than a veneer that cracks under pressure. Apparently, the satisfactory way is to develop fitness in early childhood and maintain it at a suitable level throughout life.

We have been prone to evaluate life in terms of quantity — the length of life. Today we must think in terms of quality — the elimination of accident proneness, the adaptability of the cardiovascular and respiratory systems. Fitness is more than the absence of disease. It is a positive, functional quality which enables individuals to make safe and efficient use of their bodies in everyday living.

WHAT IS IT?

Fitness is the ability to function at a high level, physically, volitionally, emotionally, intellectually and socially. While our physical fitness potential is predetermined by the type of body we inherit, the health status we enjoy, and the extent to which we develop physical efficiency, the really important thing is not so much the kind of body we inherit but rather the care we take of it, the extent to which we develop its normal powers and energies. Heredity has been and probably will continue to be kind to Canadians because of the protection that safeguards them. Health services in Canada, for the common man, are superior, and continually improving. But the "sturdiness" and the "staying powers" of our pioneers has failed to keep pace with scientific progress. Quite the reverse is true — Canadians generally possess a lower level of endurance, strength and recuperative power. They fatigue more easily and are more subject to psychosomatic tensions and stresses than were their forefathers or their counterparts in Europe today.

Physical efficiency, the hard core

Dr. Plewes is Consultant, Fitness and Recreation, Department of National Health and Welfare. This address was given at the public health nurses' luncheon.

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of fitness, is a functional condition and is determined by the individual's capacity to develop power and skill. The body, a good and wise provider, responds to demand and strives to adjust its services so as to avoid stresses and strains. The daily miracle of energy renewal is but one evidence of its efforts to balance its budget. It goes one step further and restores a bit more than was expended. Abhorring waste, it soon absorbs tissues no longer in use and limits the generation of power to meet the daily demand. The age-old-law — "use or relinquish" operates consistently.

Physical efficiency depends upon energy and power on the one hand, and on skill on the other. It is the ability to use the body's muscular and organic powers effectively, to make an all-out effort over a relatively long period of time with quality unimpaired, mental powers acute, emotions under control, without undue fatigue, and with relatively rapid recuperation after effort. Regrettably, few persons develop more than a fraction of the potential that heredity and health status provide.

Physical efficiency has two major aspects, one "basic," the other "special," both of which can be measured. The first, basic or general physical efficiency, is made up of: physique characteristics, organic power, and muscular power. The second, related to sports and work skills, is the dynamic integration of varying combinations of the three basic components mentioned above. The extent to which one can develop special physical efficiency (sports and work skills) depends upon the extent to which the basic or general aspect of physical efficiency has been developed.

Basic physical efficiency is the power part of movement and is produced by the muscles, heart, blood vessels and lungs functioning with optimum expenditure of energy, minimum fatigue and a maximum rate of recuperation from effort. Muscular and organic powers are never static; they improve or deteriorate depending on daily use. It is the daily effort that sets the ceiling.

Muscular power depends on:
The speed of movement,
The force of movement,
Muscular resistance to fatigue,
Elasticity of muscle.

Muscular power can be assessed in several ways. Bulk can be seen and firmness felt, but it is only what they do that really counts. Performance is the yardstick of competence.

Organic power depends on:
The capacity of the heart to pump blood,
The rate at which the lungs absorb oxygen,
The rate at which the blood flows,
The capacity of the blood to carry oxygen, muscle fuel and waste,
The extent to which all of these can mobilize power on demand, resist fatigue and recuperate rapidly.

Physique is evaluated and classified on the basis of height, weight and body build (stocky — medium — lineal).

Special physical efficiency is the skill part of movement and can be acquired only to the extent that the individual possesses the power to activate it. Power can be transferred from one skill to another, but each skill is specific and contributes little if any efficiency either to another skill or to the generation of power.

It has been demonstrated that muscles properly conditioned can perform the same work at least 20 per cent more efficiently than unconditioned muscles. Individuals who possess a better than average degree of basic physical efficiency can do the same amount of work more efficiently and effectively with less energy expenditure than those with less than average. One has only to compare the rigid posture of the tense to the rhythmic movement of the muscularly fit, to appreciate the difference in energy consumed, fatigue experienced and efficiency in movement.

The strategic part that oxygen plays in producing energy is seldom realized. The body is a combustion engine, burning food and oxygen to produce power. In a resting state, one cup of oxygen per minute is usually sufficient. Strenuous physical activity may consume as much as six gallons per minute. Bannister's four-minute-mile was an outstanding example of the relationship between oxygen intake and supreme achievement. Dr. Bannister's intake was greater than that of any other athlete so far recorded.


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But all is not "brawn." "Brains" play their part. Representing roughly only 2 per cent of the total body weight, the brain uses approximately 23 per cent of our oxygen intake. Consequently, the amount available for mental purposes depends upon the amount absorbed by the lungs and distributed by the circulatory system. Recently the press reported the use of oxygen cocktails in Parisian cafes as an effective means of chasing a hangover and restoring mental acuity. Adequate oxygen intake and utilization for sedentary living requires at least an average level of Basic Physical Efficiency.

The significant relationship of physical activity to a wide variety of common problems is frequently overlooked. Time permits only a passing glance at a few of them.

Overweight which is more likely to develop in adult life when eating habits have been fairly well established as the result of decreased physical effort, as much as of increased caloric intake. It is the little by little, day by day, over ten to fifteen years that puts on 10, 20, and even 30 pounds. For example, 10 to 15 extra calories per day can add 10 to 15 pounds of body weight in 15 years even if physical activity is kept at an even level. Similarly, if diet is kept constant, a very small reduction in daily physical activity can and does increase the weight 10 to 15 pounds, over the long pull of 15 years. Persons who eat just a tiny bit more and exercise just a tiny bit less each day can acquire a surprising load of excess weight. No wonder small people gain weight more easily.

Let us look at the caloric cost of walking. Speed has little if anything to do with the number of calories expended. The slow gait of the elderly burns up as much as, and sometimes a bit more than, the speedier progress of the middle-aged. A typist 63" tall, weighing 120 lbs. uses 14.8 more calories per hour using a standard typewriter than if she used an electric one.

Ebbing energies in the 30 to 40 year age bracket is a fairly reliable indication of premature middle age slow down. The business executive who no longer has the dynamic push that gained him advancement, the housewife or career woman who experiences frequent fatigue and whose personality plus is slipping — actually lacks energy.

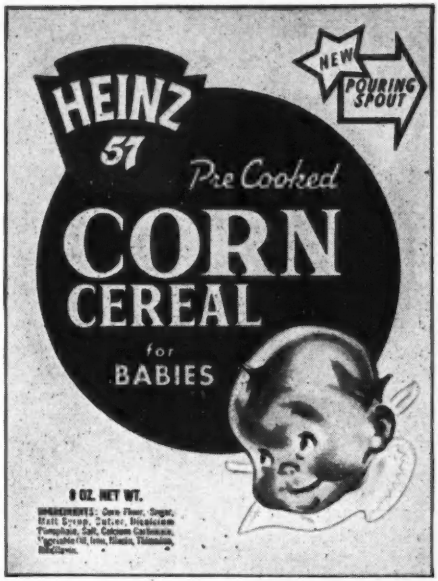
Formerly the theory was that food and rest supplied energy while physical activity depleted it. Now we know that food and big muscle activity are the sources of energy while sleep, rest and relaxation are very active phases of metabolism during which repair takes place.

By measuring what one has and knowing what the daily requirement is, the matter of balancing the physical energy budget can be tackled effectively.

To provide a practical means whereby individual basic physical efficiency could be assessed with due regard to age, sex and physique, a set of tests, known as the Canadian Physical Efficiency Tests, has been developed.

The availability of the data collected for the recent Canadian Weight-Height Survey made it possible to use a graph technique for classification purposes, thus simplifying and sharply reducing the time required for paper work. Standards for performance are helpful for reference, motivating interest, and assessing progress. The forging of valid and reliable tools for this purpose is being done cooperatively by professional and volunteer groups all across Canada.

Since specifically designed exercise is the only known means for developing Basic Physical Efficiency, the development of practical procedures which would be simple, inexpensive, less time consuming and less skill demanding are essential if even a sedentary level of Basic Physical Efficiency is to be brought within the grasp of *all* Canadians. Consequently, several series of Progressive Power Exercises were designed specifically to develop and maintain Basic Physical Efficiency. Each individual begins at a minimal level, and then progresses at his own rate until he attains the degree of Basic Physical Efficiency best suited to his needs. The basic components and procedures used are constant throughout, but the demand becomes increasingly stressful as progress is made from stage to stage and series to series. Fifteen minutes every day is sufficient if instructions are followed and a good effort is made. How many days it will take depends on where you are and how far you have to go. Once attain-



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Protein	5.2%	Sodium Chloride	1.31%
Fat	1.3%	Niacin (mg./100 gm.)	28.0
Crude Fibre	1.0%	Thiamine (mg./100 gm.)	1.26
Moisture	7.4%	Riboflavin (mg./100 gm.)	0.68
Ash (Minerals)	2.8%	Calories per 100 mg.	362
Calcium	.065%	Calories per ounce	103
Phosphorus	.108%	Tablespoons per ounce	10
Iron	.050%		

HEINZ BABY CEREALS 57

NOW WE ARE SEVEN... RICE • BARLEY • OATMEAL • WHEAT • MIXED CEREAL • INFANTSOY • CORN

ed, ten minutes daily will maintain your optimum status. Considered in terms of daily personal care, such a maintenance program becomes an integral part of one's grooming routine.

Nursing is one of the more demanding professions, any way you look at it. Nurses not only need special kinds of strength and endurance to meet the demands of their routine duties, but in addition, require considerable energy reserve if they are to be that "tower of strength" which patients so often need, and which so often tips the balance in their favor.

During convalescence so much can be done to assist the patient to begin to develop the physical efficiency he needs, to help him understand its importance, and to encourage him to carry on afterward. This opportunity for guidance toward personal rehabilitation is a rare one and the advice of the nurse is respected by most persons.

In some countries, training colleges recognize this need and provide a progressive compulsory physical training program throughout the entire training period. At graduation, the nurse has enjoyed top condition long enough to appreciate its need and value. For those who work in the public health field, fitness has added importance.

Studies concerning the influence of muscle habits on physical and emotional health are debunking some traditional theories and developing entirely new concepts of human kinetics. Industry several decades ago accepted the demonstrated fact that wrong muscle habits give rise to many injuries and disabilities resulting in absenteeism and avoidable claims for industrial insurance. The fact that only 10 per cent of accidents which necessitate absenteeism occur while on duty is a significant evidence that industry has improved job assignment training.

In an enlightened country like Canada where one of the highest standards of living in the world prevails, it is only reasonable to assume that the current prevalence of low-level physical efficiency is primarily due to:

1. Lack of awareness of the important functional relationship it bears to the quality of everyday living.

2. The scarcity of sound practical guidance in respect to its development.

Freedom from disease is so recent that we have no concept of what this will mean in increased vitality. Our present task is to develop the physical potential of the people of Canada and a dual approach is needed.

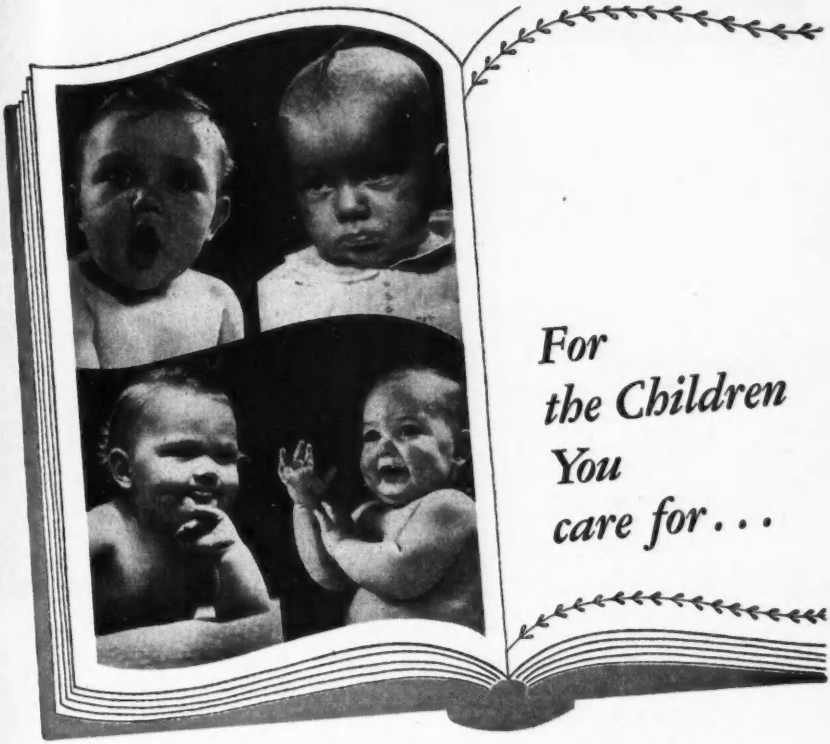
First, an "awareness" of the values and the needs must be developed at the grass root levels. People want practical proven facts not fancies and theories. Nurses by reason of their training, experience and chosen vocation are particularly able to contribute significantly to the development of a sane and sound appreciation of the facts and to the practical guidance needed to initiate "Do-it-yourself" projects.

Second, we must make fitness fashionable. Today luxurious lethargy is the fashion — movies, publications, TV and radio feature it as the ultimate goal irrespective of how rugged the struggle to the top has been. The public are just beginning to realize that gluttony and physical indolence are detrimental and that productive effort is a lifelong objective. When the public realize that basic physical efficiency is a life and death matter to some, that it influences success and the rate of progress, they will get down to business just as they have on other problems. Failure to master the three R's is deplored but physical literacy is disregarded. When society regards physical incompetence as deplorably stupid, as socially unacceptable, constructive action will snowball.

Today we must look at the human being behind the statistic and make sure that as people hurtle through their busy lives, chairbound and wheelborne, they learn ways of avoiding the erosive effects of inactivity and include the supplement needed to conserve their energies — the powers that run the human machine. The supreme importance of Basic Physical Efficiency may well become one of the most significant rediscoveries of modern times.

A family doctor is as essential as a television set. Yet in many parts of Canada there are more homes with the latter than the former.

—*Bulletin*, College of General Practice of Canada



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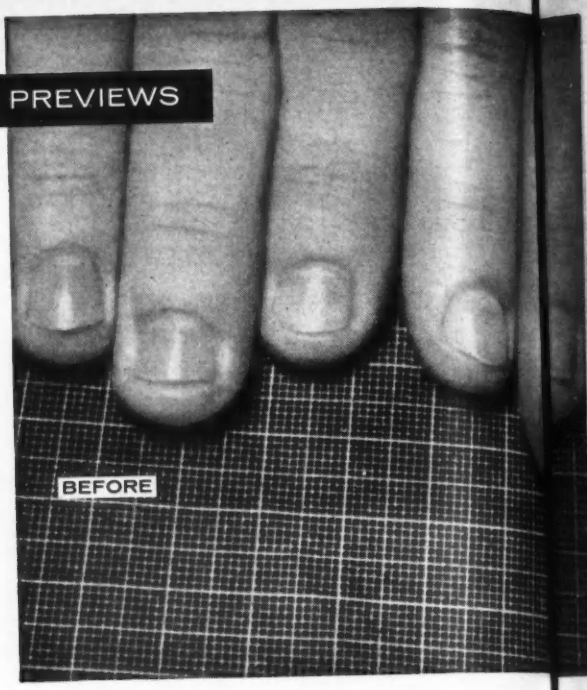
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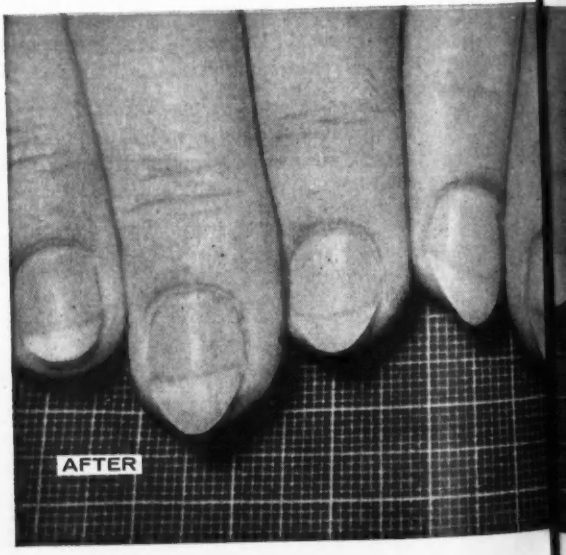
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KNOX PROTEIN PREVIEWS



TWO NEW CLINICAL REPORTS REAFFIRM THE BENEFITS OF GELATINE FOR





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Evidence continues to accumulate verifying the effectiveness of Gelatine in the treatment of brittle fingernails. Investigators report that the nails show objective evidence of improvement.[1,2,3,4] Furthermore, patients often volunteer that their nails "feel stronger," "look smoother," and "I can pick up things without them hurting."[1] Evidently the subjective sensations associated with improvement are nearly as important to some patients as the positive physical change in the nails' appearance.

Improvement Noted in 81% of Patients

See the chart below for a summary of the effect of Knox Gelatine in brittle fingernails as observed in all published reports. Photographic evidence of improvement, much of it in color taken before and during treatment, is available for most of the patients.[1,2,3] Please note, however, that where Gelatine was used in the treatment of pathological conditions associated with brittle fingernails only in psoriasis did the data show definite improvement.[1,3,4]

Response to Gelatine in Brittle Fingernails

References	Dosage	Duration of treatment	No. patients w/ brittle nails	No. patients improved	No. patients w/ brittle nails and other pathology	No. patients improved.
1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat.* 76:330, (September) 1957	7 Gm./ day	3 months	50	43 (86%)	32[a]	9
2. Schwimmer, M. and Mulinos, M.G.: *Antibiot. Med. & Clin. Therapy* 4:403, (July) 1957	7.5 Gm./ day	11-16 weeks	18	15 (83%)		
3. Rosenberg, S. and Oster, K. A.: *Conn. State Med. J.* 19:171, (March) 1955	7 to 21 Gm./day	15 weeks	36	26[b] (72%)		
4. Tyson, T. L.: *J. Invest. Dermat.* 14:323, (May) 1950	7 Gm./day	13 weeks	12	10[c] (83%)		
Totals	7-21 Gm.	11-16 weeks	116	94 (81%)	32	9 (28%)

a. Gelatine improved psoriatic nails in 5 out of 12 cases. In onychomycosis and other pathological conditions of the nail it was of no appreciable help.

b. Of the failures, 2 had congenital disease of the nails, 3 were diabetics and 3 took the medication for less than one month.

c. One patient with psoriasis and arthritis and one patient with psoriasiform nail changes showed improvement in 2 and 3 months respectively.

BRITTLE FINGERNAILS

Important Note

The pharmacodynamic effects of Gelatine are manifested through its high Specific Dynamic Action, and therefore, depend upon adequate and prolonged intake. All published clinical research has been conducted using 7 to 21 grams (1-3 envelopes) of Knox Gelatine per day for the three to four months that are required for complete regrowth of the nails. Smaller dosage would induce a lesser specific dynamic action and thus prove ineffectual in correcting the brittle nail defects. More detailed information on brittle fingernails and reprints of the two more recent clinical reports are available on request. Please use the attached coupon.

Knox Gelatine (Canada) Limited
Professional Service Department CD-43
140 St. Paul St. West, Montreal, Quebec

Please send reprints of the following articles:

☐ Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat.* 76:330, (Sept.) 1957.

☐ Schwimmer, M. and Mulinos, M.G.: *Antibiot. Med. & Clin. Therapy* 4:403, (July) 1957.

YOUR NAME AND ADDRESS

A Public Health Affiliation Program

LUELLA DOWNING, B.N.

AWARENESS OF THE PATIENT as an individual, consideration of the social factors in the situation, and understanding and teaching of positive and preventive health cannot be taught by textbook or lecture. It must be lived, acted and practised. The very set-up of the hospital itself, therefore, must be that of a cooperating community agency.

Because an outpatient clinic is in reality a link between the hospital and community, this should be one of the most rich and fruitful experiences in the basic program. Curriculum committees, school administrators, and nursing supervisors are not in agreement as to the placement of outpatient nursing in the sequence of the student's experience. In order that the student may understand the patient's care in its entirety, the outpatient experience should be combined with each hospital service such as medicine, pediatrics, obstetrics and surgery.

By using this plan of teaching and experience, the student would be introduced to the community problems in preservation of health and the care of the sick, early in her professional course. The community, the family and their problems would be kept before her throughout the entire basic curriculum, culminating in an eight weeks' period of practice in home and community nursing under the supervision of a visiting nurse service.

The planning, organization and direction of the learning activities of the student nurse in the outpatient department is equally as important as the program in the other clinical fields of the hospital.

If the student nurse is to learn the effect of social, psychological, and economic factors upon individual patients, emphasis must be given this phase of experience. Time must be available for students to learn to know the patients rather well. There are many important tools to provide such learning. An adequate clinic history, for instance, will reveal the social and economic situation. It will relate the affect of this on the disease process. There may be a dietary history, facts in regard to home and job relationships, and records of previous visits or interviews with the medical social worker. The outpatient department provides an excellent opportunity to demonstrate the relationships with various social and health agencies.

The student's ability to observe and recognize the importance of symptoms, during her outpatient experience, will be strengthened. She must, as a part of her responsibility, be aware of the importance of noting symptoms which are unrelated to the condition that brings the patient to the clinic. For example, the nurse should be able to recognize skin lesions, such as rashes of various kinds, and call such symptoms to the attention of the doctor.

Another objective of practice in the outpatient department, is, of course, the development of skill in assisting with the examination and treatment of ambulatory patients. She should be given experience in such techniques and procedures as:

In the eye clinic — testing visual acuity, how to evert an eyelid.

In the ear, nose and throat clinic — ear irrigations, bronchoscopy, removal of foreign bodies from ears, nose.

In the orthopedic clinic — draping a patient for a bone and joint examination, care of skin upon removal of a cast, use of crutches and canes.

The outpatient department offers excellent opportunities to acquire ability in making and carrying out teaching plans for individual patients and for groups of patients. There will be a certain amount of incidental teaching done by the student in the outpatient department, but the instructor should plan satisfactory teaching experiences in relation to certain specific conditions. For example:

Miss Downing has been studying at Teachers College, Columbia University during this past year.

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*Benson, R. A., and associates. J. Pediat, 34:49, 1949
Klarmann, E. G., and Wright, E. S., Soap San. Chem. 22:125, 1946

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Diabetic Clinic — 1. Principles and techniques of preparing and administering an injection of insulin.

2. Importance of proper care of the feet.

Orthopedic clinic — 1. Principles of good posture.

2. Care of a cast in the home.

3. How to apply slings, splints, braces.

Tumor clinic — 1. Care of draining lesions, proper disposal of soiled dressings, prevention of odors.

2. Details of oral hygiene in the care of patients with cancer of the mouth.

Group teaching may be arranged for patients whose health needs are similar, such as, patients with pulmonary tuberculosis.

The student should keep a record that would include the types of patients with whom she has had experience; the symptoms she has observed; the experience gained in the administration of medications and in the procedures commonly done in a clinic; and the social problems observed in relation to the patients.

No patient should be discharged without consideration of where he is going, what home situation he is going into, and what care he will receive when he gets there.

The responsibility for the patient's total care insofar as continuity of medical and nursing care is concerned should be shared by the nurse, doctor and social worker. It is an excellent experience for the student nurse, under the supervision of the head nurse, to plan for her patient in the area of nursing care in the home and the interpretation of medical orders. The ideal plan would be to delegate the home care to the nurse who has cared for the patient in hospital, thus forming a direct "sidewalk" from the hospital to the home.

Let us now discuss a program in which this plan is carried through very effectively. It is one in which the hospital, in cooperation with one district of the City Health Department, provides a supervised field experience, including a bedside nursing service for patients in their homes, and selected observations in the generalized preventive health program. Opportunity is thus provided to extend the student's knowledge of the health and social aspects of nursing, and to coordinate and apply in actual situations the knowledge previously acquired.

Program Objectives

1. To create an increased understanding of the function of nurses belonging to official and nonofficial public health agencies in a well-defined generalized program that emphasizes family health.

2. To apply all previously acquired knowledge to the care of patients in homes, schools and clinics, and to work harmoniously with all allied groups.

3. To give nursing care to the sick in their homes and to teach a responsible person regarding the care of the patient.

4. To teach individuals and their families how to protect themselves and others from disease and how to improve their own physical and mental health.

5. To learn the value of careful recording as a means of caring for the patient, and of assisting in the larger health program.

6. To recognize health and related social problems, and to work with community health and social agencies in securing a safe, sanitary, comfortable and convenient environment for patients and their families.

7. To develop and intelligently use the nurse-patient relationship in a therapeutic manner to the benefit of the patient and the family.

8. To develop social consciousness and an attitude of responsibility toward needed change in social institutions, and to initiate when necessary, promote, and support essential remedial, ameliorative and preventive social health facilities.

9. To develop a research attitude and give some practice in research methods.

At Johns Hopkins Hospital, for example, 10 students are assigned for community nursing experience at one time. The group is divided so that four students receive their experience with a branch of the City Health Department and six students remain with the Dispensary Visiting Nurse Service of the hospital. This experience may be planned for the latter part of the second year, or the early part of the student's third year in the nursing program. The requisites around which this program functions are:

1. Incorporation of the social and health aspects of nursing throughout the entire basic curriculum.

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*Lord Cohen of Birkenhead: British M. J. 1:672, 1958.

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2. Completion of at least the major portion of theory and clinical practice in the four basic services: medicine, surgery, pediatrics and obstetrics.

3. Organization and administration of the joint program in accordance with the generally accepted principles of public health nursing.

4. Qualified teaching supervisors who are responsible for the student program. The director of the City Health branch is a member of the hospital faculty, and is very familiar with the basic program. The ratio of supervisors to students is 1:3 respectively.

5. A statement of the student's general background including her health record, ability, and special needs and interests furnished by the hospital school.

6. An evaluation record prepared by the health agency upon completion of the student's experience.

7. Release of the students from all service in the hospital, and classes in the school of nursing during the period of community nursing.

8. Frequent conferences between the staffs of both the health agency and Dispensary Visiting Nurse Service as a means of better correlation of the program of instruction.

9. Responsibility for the maintenance of the students, including the health program, assumed by the school of nursing.

10. Provision by the agency and Dispensary Visiting Nurse Service for the student's transportation on duty and necessary nursing equipment. The uniform worn is that of the school which is acceptable to the agency.

The first week of the program is a carefully planned introductory period which provides opportunity for orientation to the policies and services of the city agency or the Dispensary Visiting Nurse Service. This orientation is in the form of observation and demonstration in the office and home, of the technique for the use of the equipment carried in the nurse's bag; discussion of the principles of public health nursing which includes interviewing, and the manner in which the nurse enters the home and proceeds with the care of the patient.

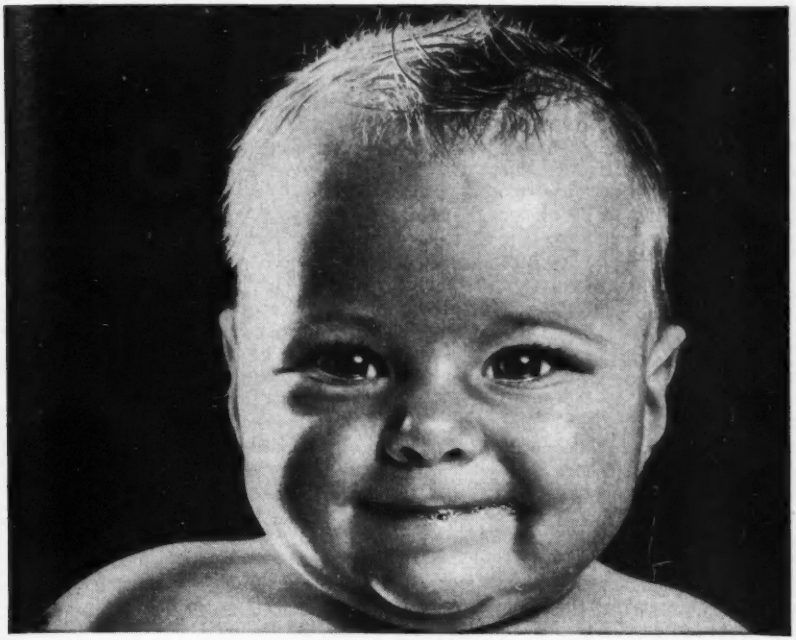
Since this is an introduction to a family health service where all the members of the patient's family are the nurse's clients, family interrelationships and their guidance are an inevitable part of the program of total care for the patient. Discussions include the philosophy of total patient care and what it implies in relation to the patient, his family and the community; the science and art of initiating rapport with the patient and his family; the differences between "imposed" teaching and guidance in the reconstruction of values, attitudes and motives that underlie acceptance by the patient and the family, of new and healthier practices.

The student experiences a practice period in the office in which to demonstrate back to the instructor the technique and use of the equipment before she actually carries out a procedure in the home. The enactment of a visit during this demonstration may serve as a pretest in which the instructor takes the part of the patient. The instructor may choose to enact the prenatal patient and may ask questions concerning diet, swelling of feet and blurred vision. She may choose to take the part of a medical patient who may be the mother of several children. In this instance the questions directed to the student may be problems in child care such as thumb sucking, enuresis.

The student, during field observations, accompanies the supervisor to the homes and observes different types of nursing service visits, such as, morbidity, maternity, child health and health supervision. The case histories are reviewed before the visits are made and the student sees the practical application of that which was demonstrated in the office.

After one week of orientation, she is ready to start out on her own. Her patient and family assignments are small in the beginning and are increased according to her ability to perform. The instructor assigns patients so that a variety of experience is included in her program. The student makes an average of four visits a day. Her visits are planned with the guidance of the instructor, and according to the patient and family need. She is supervised closely throughout her experience.

Due to the development of interlocking relationships with all social and health agencies of the community, those



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patients who have been referred for home nursing and are not selected by the Dispensary Visiting Nurse Service for the student educational program, are referred to a suitable community agency.

The community observations planned for the program include school nursing, a Well Baby Clinic and Venereal Disease Clinic. Other observations that have been found to be of considerable interest and value are those to a school for handicapped children, a community recreational centre, and to an industry with a well-established health centre.

At the end of the student's first four weeks in the public health field, she chooses a family she is interested in for family study purposes. She prepares her outline with guidance and proceeds to work closely with her family for the last four weeks of her public health experience.

She clears the family with the Social Service Exchange and ascertains the community agencies that have been or are working with the family. She assumes responsibility for taking the social history of the family. She works with the hospital social workers, and with workers of community agencies that are actively interested in the family.

Many student nurses have had the opportunity of associating with such persons as school teachers, the probation officer from the Juvenile Court, the Red Cross worker, housing administrators, parish priests and ministers, camp directors, recreational directors and nursing home directors. Since all patients of the families carried by the Dispensary Visiting Nurse Service were attending one of the clinics in the outpatient department of the hospital, the student would contact the doctor and report the patient's progress at home, or she would send a written report to the doctor which would later be entered on the patient's hospital record.

There were occasions when the student nurse, with guidance, would summon a conference including the doctor, social worker and dietitian. This was done to talk over problems encountered in the home and to obtain direction in helping the family to iron out their problems. The family case history was completed in the eighth week of the student's public health experience. It was presented in the presence of the workers from the interested community agencies who were invited to participate in the discussion. This served to promote a better working relationship, and to strengthen the bonds between the hospital and community workers.

The student's progress was discussed with her throughout her public health experience. Final evaluation and discussion took place on her last day in this field. She read and discussed with the supervisor the summarization of the impressions of her nursing abilities. This was later filed in the nursing school office with her permanent record. A comprehensive report of the student's performance is filed in the Dispensary Visiting Nurse Service. It may be referred to later for purposes of recommendation should a health department or other community agency request such a pre-employment report.

It has been interesting to observe the increased understanding of the social and economic components of illness that the student carries with her and is able to put into practice when she returns to the hospital wards. Many students have stated that they had learned more during their community experience than during the whole of their clinical program. It was not that they had gained more knowledge, but that they had lived, acted and practiced all that had been learned in the clinical program.

The holes in rubber door mats were originally designed to allow water to run off and to reduce the slipping hazard in wet and snowy weather. But the mat designers did not anticipate the mad vagaries of those who design women's attire. The almost pinpoint heels on the new styles in women's shoes have given rise to a rash of accidents on the very doorstep of the hospital. The heels catch in the holes of the mat, and the lady is thrown, right into the arms of a lawyer and sometimes for a lengthy stay in a hospital bed. —*Safety Newsletter*

* * *

The word "esposa" in Spanish means both "wife" and "handcuff."

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The perfect slip to wear under Reitman's pert uniforms . . . styled in crisp white cotton with all-around double skirt, guaranteed shadow-proof. Imported embroidered eyelet trim. Sizes 32 to 40 in proportionate lengths: Short (to 5'2") Average (to 5'4") Tall (over 5'5") **2.95** each

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Nursing Profiles

This month **Margaret Lorena McColl,** "Laurie" to her many friends, joined the professional staff at National Office as assistant secretary. Born in Neepawa, Man., of Scottish-Canadian descent, Miss McColl was educated in Moose Jaw, then clerked in a department store for a couple of years while she made up her mind what she wanted to do with life.

Choosing nursing, Miss McColl enrolled in the General, now Union, Hospital in Moose Jaw, graduating in 1939. Public health nursing appealed strongly to her after a brief taste of general duty. She joined the provincial nursing service and, with North Battleford as her headquarters, travelled extensively throughout the northwest corner of Saskatchewan in the performance of her duties. She secured her certificate in public health nursing from the University of British Columbia, later completing her studies in the advanced course in public health administration at the University of Toronto.

In 1947, Miss McColl was appointed senior nurse in charge of the service given by the Swift Current Health Region. Two years later she returned to North Battleford in the senior position. In 1954 she became camp organizer and director of the Saskatchewan Council for Crippled Children and Adults, which work she has recently left.

Miss McColl is greatly interested in many church activities, especially enjoying work with children's groups. Dearest of all her hobbies is the joy of going camping. The proximity of the Gatineau valley and mountains to Ottawa will be a source of pleasure to her.

National Office welcomed another new member to the professional staff **Frances Margaret Howard** has been appointed assistant secretary-nursing. In this capacity she will work closely with the nursing secretary and the director of the Pilot Project.

A graduate of the General Hospital, Saint John, N.B. in 1943, Miss Howard obtained her early education and teacher training in Fredericton before deciding upon nursing as a career. Following postgraduate study in obstetrical nursing at the Boston Lying-In Hospital, Mass., she remained on the staff for a short time as assistant supervisor of the delivery room. In 1948 she accepted an appointment at the General Hospital of Port Arthur, Ont. as obstetrical supervisor and instructor where she remained until 1953 — the year of her enrolment at the University of Toronto. After completing studies for her certificate in nursing education, Miss Howard went to the General Hospital, Oshawa, Ont. as nursing arts instructor where she was a valued member of the staff



(Charmbury's Studio)

M. Lorena McColl



Frances M. Howard



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during 1954-58. She resigned early this year to accept her present position.

A past president of the Ontario County Chapter, District 5, R.N.A.O., she was the convener of the program and public relations committees this year. Off duty Miss Howard is a hi-fi enthusiast with a special interest in classical and semi-classical music. Her membership in Beta Sigma Phi and the International Business and Professional Women's Organization provides stimulating companionship with women of her own profession and other fields.

Earlier this year a dream came true when the Board of Governors of McGill University granted a chair of nursing to the McGill School for Graduate Nurses. It was a moment of rich reward for those who had worked so faithfully and tirelessly toward this goal. Subsequent to this announcement came the word that Miss **Rae Chittick**, who has been the director of the School since July 1953, had been appointed a full professor in nursing — the first Flora Madeleine Shaw Professor in Nursing.

Formed in 1928, the Flora Madeleine Shaw Committee had two main purposes — to honor the founder and first director of the School; to establish a permanent endowment and "a chair of nursing." No one can deny the faithfulness with which these obligations have been fulfilled. For a period of time the very existence of the School depended upon the financial support provided by this committee. But always in the background, during the troubled times, was the hope that some day the dream of a permanently endowed chair of nursing would materialize. Two women, distinguished alumnae, have taken leading roles in achieving the final goal. Miss **Eileen C. Flanagan**, Director of Nursing, Montreal Neurological Institute has been the chairman of the committee since 1949. Miss **Blanche Herman,** Montreal General Hospital, has served as secretary since 1952, and was treasurer for several years at the time that the financing of the School was the main endeavor. The successful attainment of the coveted chair of nursing is, in large measure, due to the effort and persistence of these members.



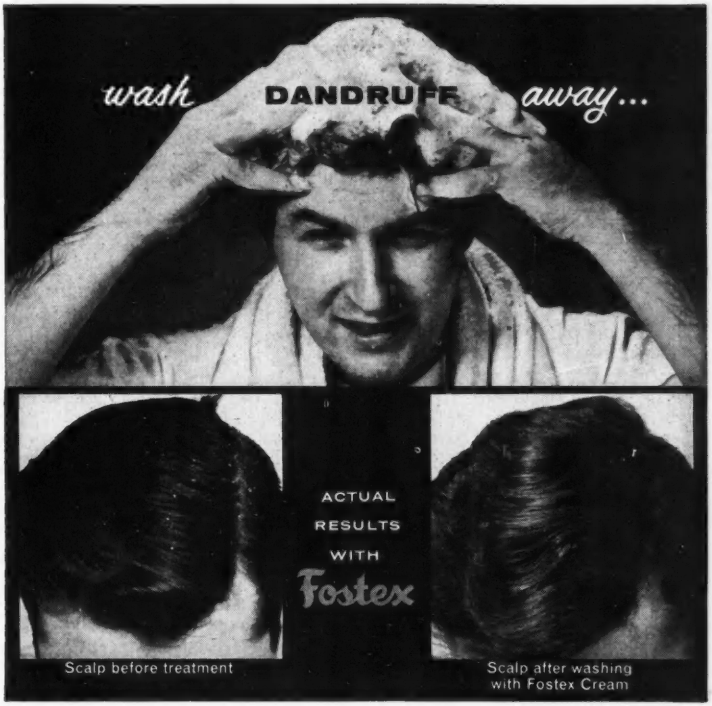
RAE CHITTICK

As the first Flora Madeleine Shaw Professor in Nursing, the McGill School for Graduate Nurses is particularly fortunate in having some one with Miss Chittick's background of preparation. A graduate of the Johns Hopkins Hospital, Baltimore, she holds the degree of Bachelor of Science in Nursing from Teachers College, Columbia University; a Master of Arts degree in education from Stanford University and the degree, Master in Public Health from Harvard University. In recognition of her outstanding contribution in the field of general education as well as nursing, Miss Chittick received an honorary LL.D. from the University of Alberta in May, 1954.

A national figure in Canadian Nursing. her breadth of knowledge and experience will contribute much to the future development of the School.

Alumnae of the McGill School for Graduate Nurses will be interested to know that the original name is being retained, although the chair in nursing assumes the official title of the Flora Madeleine Shaw Chair in Nursing. The Committee is to continue to function also. The project presently under sponsorship is the writing of a history of the School. This is to be carried out by **Agnes (Tennant) Johnston**, a graduate of the Montreal General Hospital, the McGill School of Social Work, and the McGill School for Graduate Nurses.

In June the news that a School of Nursing was to be established at the University of New Brunswick brought rejoicing in that province which was shared by nurses across Canada. Now it is with pleasure that the appointment of **Katherine Eva MacLaggan** as Director of the school is announced.



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Supplied in 4.5 oz. jars.

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Fostex effectiveness in seborrhea capitis is provided by Sebulytic® (sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate, sodium dioctyl sulfosuccinate), a new combination of surface active cleansing and wetting agents with remarkable antiseborrheic, keratolytic and antibacterial action, enhanced by sulfur 2%, salicylic acid 2% and hexachlorophene 1%.

Fostex Cream is also used for therapeutic washing of the skin in acne.

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KATHERINE E. MACLAGGAN

A Maritimer by birth, Miss MacLaggan received her early education and her preparation as a teacher in her home city, Fredericton, N.B. Becoming interested in nursing, she entered the School of Nursing of the Royal Victoria Hospital, Montreal, and graduated in 1943. In 1944 she enrolled in the McGill School for Graduate Nurses and obtained her diploma in public health nursing in 1945. Two years later she returned to the same institution to study for her diploma in supervision and teaching and in 1952 she completed her requirements for the degree, Bachelor of Nursing. Last year Miss MacLaggan obtained her Master of Arts from Teachers College, Columbia University, majoring in administration in nursing education. Immediately prior to her present appointment she was the assistant Director of Public Health Nursing for the province and a faculty member of Teacher's College, Fredericton.

The interest of the New Brunswick Registered Nurses' Association in developing and improving nursing within the province is manifested by the whole-hearted cooperation accorded studies relating to it. The study carried out by Miss E. Kathleen Russell was a major project initiated by the University of New Brunswick, financed by a federal grant, and enthusiastically supported by the N.B.A.R.N. As an early step in the implementation of recommendations contained in the Russell Report, a program of inservice education was developed by the provincial association with leadership from the CNA. One of the functions of the new school will be to assume responsibility for this program.

Throughout this phase of development and improvement, Miss MacLaggan has given able and devoted leadership first as chairman of the provincial nursing education committee and later as chairman of the Planning Committee charged with implementing the recommendations in the Russell Report. Her present appointment will provide further scope for her administrative ability and sincere interest in nursing education. Organizational plans for the new school are to be completed in time to admit the first class of students in September, 1959.

"Happy birthday to you!" So writes Fraulein Olga von Lersner, Director of the School of Nursing at Heidelberg University, as she joins with many other graduates to send greetings on this the 25th anniversary of the School of Nursing, University of Toronto.

From the original small Department of Public Health Nursing established in 1920 the present school of nursing was organized in 1933. Through the years there have been many changes in the basic and postbasic programs. Today a four-year basic course is offered leading to the degree of Bachelor of Science in Nursing. This course prepares students for both hospital and public health nursing. One-year certificate courses are offered to postbasic students as well as a three-year course leading to the Bachelor's Degree. Throughout its history the School has given many short refresher courses and workshops.

Now, 1958 marks our silver anniversary. To celebrate the occasion, Open House will be held at the School at the time of the University Homecoming Week End. Classes in the basic and postbasic courses will be open to visitors on Friday and Saturday. A tea in Cody Hall is being planned for Sunday afternoon. There will be tours of the new School building throughout the week end. A focal point of the celebrations will be the display of the work and activities of both undergraduates and graduates.

It is the hope of staff, students, and alumnae, that as many friends as possible will join in these anniversary celebrations. We shall look forward to seeing you at 50 St. George Street, Toronto, on October 17, 18, and 19, 1958.



Check-up on a pin-up!

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Now Farmer's Wife offers the doctor his choice of *four* special baby milks—Whole, Partly Skimmed, Skimmed—and the new Farmer's Wife PREPARED FORMULA, with the carbohydrate already added. This fourfold variety makes it *easy* for the doctor to prescribe for each baby's individual dietary needs. It makes the preparation of a constantly accurate formula *easy* for the mother.

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"HELLO!"

Called the maple five stories high
To the patients in five one two,
"I've been waiting till you were well
To lean over and chat with you.
I'm stationed as Nature's nursing aid
To help you recuperate,
And I plan my program every day
With selections to animate.
I hope you enjoy the rain that plays
Like a xylophone on my leaves,
And keeps them fluttering up and down
With a grace that a ballet achieves.

AND SAY!

You should know I'm on night duty, too,
Standing guard while you're lost in sleep.
The lights and stars filter through my leaves
And I do try my best to keep
The winds from rustling my branches too much.
And when the birds start singing at dawn
I urge them to soft pedal their joy
Till I hear you wake up and yawn.
I stand here between you and the storms
So that you might feel at ease,
And love to pass on, in weary heat,
The refreshing summer breeze.

I KNOW

You are thankful to God up above
For the skill of the doctors here
And appreciate beyond a doubt
The nurses and their patient care.
I can hear you express gratitude
To the aids for their watchfulness
In keeping your every want supplied
In a manner of cheerfulness.
I offer a prayer of blessing, too,
When I see you up well and strong
And hope when you leave the hospital
You'll take thoughts of me along."

A 12-nation group of WHO experts recently urged large-scale trials of a new polio vaccine prepared from living virus.

The live virus vaccine is taken by mouth instead of being injected. If the trials prove successful, the vaccine will provide reliable and long-lasting immunization against paralytic poliomyelitis. It will also bring about the elimination or substantial reduction of virulent strains of polio now in circulation.

It was emphasized that the new vaccine should be considered an adjunct to the Salk vaccine, although it might eventually replace it or serve as a substitute.

—*The Canadian Hospital*, September, 1957

* * *

A drop in diphtheria's death tool from 2075 in 1921, to the low figure of eight in 1956, is a dramatic change. When every child is immunized against this disease, it will be wiped out as thoroughly as smallpox.

— Dept. of National Health & Welfare

Fear of cancer is one of the worst aspects of the disease, many people misinterpreting symptoms and worrying over them. A doctor should always be consulted at any suspected sign of the disease so that early treatment may be given.

— Dept. of National Health & Welfare

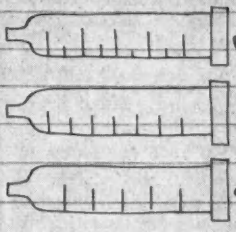
* * *

To help parents select the toys that will be the tools for their children's growth and development, the National Society for Crippled Children and Adults has just published the first authoritative full-color toy selection guide, authored by Mrs. June Frantzen, registered occupational therapist. Copies can be obtained from the National Society for Crippled Children and Adults, 11 S. La Salle Street, Chicago 3.

* * *

You could read Kant by yourself, if you wanted; but you must share a joke with someone else. —STEVENSON

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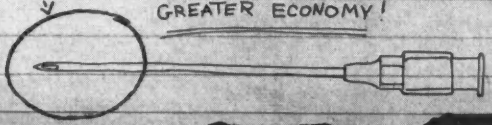
② CLEAR GLASS BARRELS - better visibility more accurate dosage - far outlast ground barrels.



③ NO-LEAK GLASS TIPS available - best type for I.V. use.

④ NEW LAMINEX ALLOY STEEL - stays sharp for double usual no. of injections lasts twice as long as ordinary needle.

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PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

CNA Staff

This month we, in National Office, welcome two new members to our staff.

Miss Laurie McColl of Saskatoon, Saskatchewan joins us as Assistant Secretary. Her duties will include responsibility for the international program of National Office. In addition she will assist the General Secretary, particularly in the work relating to the Committees on Finance and Legislation and Bylaws. One of her first duties will be to plan the study tour for 17 British nurses who will visit Canada from October 3 — 28, 1958.

Miss Frances Howard of Oshawa, Ontario comes to National Office as Assistant Secretary — Nursing. She will work closely with the Nursing Secretary and the Director of the Pilot Project and will assist in the detailed work pertaining to nursing service and nursing education.

We are pleased to welcome these nurses to National Office staff. This additional nursing personnel will, we know, permit us to develop the rapidly expanding work of our national association for the benefit of Canadian nurses.

Registration 2,356

Were you one of the 2,356 nurses who attended the largest CNA General Meeting in the history of the Association? If not, you will have enjoyed reading Miss Kerr's and Miss Charbonneau's interesting account of the convention activities in the August issue.

From all reports the nurses enjoyed the meeting and the story of nursing in Canada as portrayed in the theatrical production "Cavalcade in White." On both evenings this production, held in the Coliseum, played to an almost full house. Approximately 3,400 people could be accommodated in the hall.

See You in Halifax

These were the parting words of many as they bade farewell to friends at the close of the convention. The reason — the Registered Nurses' Association of Nova Scotia has extended an invitation to hold the 1960 30th Biennial Meeting in Halifax.

The CNA Executive Committee has been invited to hold its postconvention meeting of that year in Prince Edward Island.

And so it is — see you in Halifax in 1960.

Pilot Project

By now the survey of four schools of nursing participating in the Pilot Project for Evaluation of Schools of Nursing is almost complete. It is expected that by March 1959 the 25 participating schools will have been surveyed.

The Board of Review responsible for reviewing and evaluating all survey reports will likely meet in mid-October.

Pension Plan a Reality

The pension plan as recommended by the CNA Executive Committee was accepted at the June General Meeting.

This retirement plan is similar to that adopted by the Canadian Medical Association. It will be available to nurses employed by hospital or health agencies as well as to nurses who are



NOTICE TO NURSES

The Surgical Products Division, Cyanamid of Canada Limited, takes pleasure in announcing a new development of outstanding importance to your hospital...and to your patients.

In the past we have worked with surgeons and hospital personnel to introduce such important product advances as the new all-purpose D & G Elliptron* Surgical Needle, the revolutionary D & G Surgilar® and D & G Surgilope SP* plastic suture packages that give you safer, stronger, more flexible sutures, and a complete line of Vim hypodermic syringes and needles.

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The DIRECT-PURCHASE PLAN is bound to become an important topic of discussion among your hospital associates. We think you'll agree that it marks one more important step in our comprehensive program to bring your hospital the finest products at the lowest possible cost.

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self-employed. One part of the plan provides for employer-employee participation.

The National Life Insurance and Royal Trust Companies who will administer the plans are preparing an information booklet that will be distributed through the provincial registered nurses' associations to all CNA members. Registration of applicants for the plan will be handled through CNA National Office.

Gift for CNA House

It has been agreed to set up a fund for our own national headquarters — CNA House. It is the hope that within the next few years the CNA will move into its own building.

A gift has already been received in National Office for CNA House. The donor was — the staff of the Victorian Order of Nurses for Canada; the gift — two beautiful silver ash trays with the engraved initials CNA.

We are delighted with this gift and look forward to the day when it will be displayed at our housewarming.

Convention Report

A report of the 50th Anniversary General Meeting is being prepared by National Office in both French and English. At the time of writing it is expected that this report will cost approximately $2.00. Requests should be directed to: Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa.

Business Firms Assist CNA

Once again the T. Eaton Co. Limited provided the attractive programs for the CNA General Meeting. The cut for the cover, which carried a colored picture by Karsh of the Parliament Buildings as seen at tulip time, was provided by the Tourist & Convention Bureau of Ottawa. A beautiful souvenir of the half-century anniversary of the Association.

In order to provide a means for each registrant to carry all the convention material that she is given, it has been the custom to enclose the material in a specially prepared folder. This year Murphy-Gamble Ltd. of Ottawa provided us with very attractive folders in the firm's colors of gray and white. Admired by all the nurses, these folders were used throughout the week and have now been carried home to all parts of Canada.

The programs for Cavalcade in White were prepared for us by A. J. Freiman Ltd. of Ottawa. In white with a gold border indicating the golden anniversary, the program carried pictures of the star performers and the producer. This was another souvenir treasured by nurses in all parts of Canada and abroad.

Our thanks are here expressed to these business firms for their generous contribution to the success of the Golden Anniversary Convention.

Results of Elections

The officers for the coming biennium are: President, Miss Alice Girard; First Vice-President, and Chairman of the Committee on Finance, Miss Helen Carpenter; Second Vice-President and Chairman of the Committee on Legislation and Bylaws, Miss E. A. Electa MacLennan; Third Vice-President and Chairman of the Committee on Nursing Education, Miss Hazel Keeler.

Chairman of the Nursing Service Committee will be Rev. Sister Mary Felicitas. Mrs. Isobel MacLeod will again be chairman of the Board of The Canadian Nurse Journal.

The following Religious Sisters have been elected as members of the Executive Committee: Rev. Sister Madeleine of Jesus, Ottawa; Rev. Sister Mary Felicitas, Montreal; Rev. Sister Mary Irene, Charlottetown; Rev. Sister Mary Laurentia, Moose Jaw.

"I won't" is a tramp.
"I can't" is a quitter.
"I don't know" is lazy.
"I might" is waking up.
"I will try" is on his feet.
"I can" is on his way.
"I will" is at work.
"I did" is now the boss.

* * *

Talking and eloquence are not the same; to speak and to speak well are two things.
—Ben Jonson

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Prevents Dry Skin • Protects against the Weather

Sun, wintry winds, even routine hospital duties can rob skin of its natural oils. Make it dry, rough, and red. That's why so many nurses use Nivea Creme to keep their skin soft, smooth, and supple.

For they know Nivea contains a special ingredient, Eucerite, that closely resembles the natural oils of the skin. The ramarkable agent penetrates the skin's top layers to feed and nourish it — keep it fresh and fragrant.

And here's a tip to keep you looking your best on those important dates — Nivea makes an excellent powder base.

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Le Nursing à travers le pays

Secrétariat de l'AIC

Ce mois-ci nous avons accueilli avec plaisir deux nouveaux membres dans notre personnel.

Mlle Laurie McColl, de Saskatoon, Saskatchewan occupe maintenant le poste de secrétaire adjointe; ses devoirs comprendront entre autres, la responsabilité du programme international de notre bureau national. Elle assistera, en plus, la secrétaire générale dans le travail qui a trait particulièrement aux comités de finance et de législation et règlements. Une de ses premières fonctions sera l'organisation à une tournée d'études pour 17 infirmières britanniques qui visiteront le Canada du 3 au 28 octobre 1958.

Mlle Frances Howard, d'Oshawa, Ontario, occupe la fonction de secrétaire adjointe, section du nursing. Elle travaillera de concert avec la secrétaire du nursing et la directrice du Projet-Essai et contribuera au travail concernant le service du nursing et de l'éducation en nursing.

L'addition de ces deux membres à notre personnel facilitera, nous en sommes assurées, l'exécution du travail sans cesse croissant de notre association nationale, pour le plus grand bien des infirmières du Canada.

Inscription — 2,356

Etiez-vous une des 2,356 infirmières qui ont assisté à la plus grande assemblée générale dans l'histoire de l'Association? Si non, vous avez dû lire avec intérêt l'intéressant compte-rendu du congrès, publié par Mlles Kerr et Charbonneau, dans le numéro du mois d'août.

Selon tous les rapports reçus, les infirmières ont trouvé très intéressant le congrès ainsi que l'histoire du nursing si éloquemment illustrée dans le jeu théâtral "Cavalcade in White" — qui a fait salle comble les deux soirs de sa présentation. La salle contenait environ 3,400 personnes.

Bienveillant Concours des Maisons d'Affaires

Encore un fois, la maison T. Eaton Co. Limited a fourni les attrayants programmes pour l'assemblée générale de l'AIC; la photo en couleur des bâtisses du Parlement, telles qu'elles apparaissent au temps des tulipes en fleurs, et qui en ornait la couverture a été gracieusement fournie par le Tourist & Convention Bureau d'Ottawa; ce programme est un beau souvenir du cinquantenaire de l'Association.

Afin de permettre aux membres de conserver tout le matériel intéressant recueilli durant le congrès, un garde-notes est ordinairement remis à chacun. Cette année, la maison Murphy Gamble nous en a offert de très jolis, aux couleurs de la maison, gris et blanc, que toutes les infirmières ont admiré, dont elles ont apprécié l'utilité pendant toute la semaine et qu'elles ont apportés avec elles dans toutes les parties du pays.

Les programmes de "Cavalcade in White" ont été préparés par la maison A. J. Freiman Ltd. d'Ottawa. Blanc avec bordure dorée rappelant le Jubilé d'Or de l'Association, le programme portait les photos des vedettes et du metteur en scène de la pièce: un autre beau souvenir pour les infirmières du Canada et d'autres pays.

Nous exprimons à ces maisons notre sincère reconnaissance pour leur généreuse contribution au succès du congrès qui a marqué le Cinquantenaire de l'AIC.

Nous nous reverrons à Halifax!

Ce furent les mots d'adieu ou plutôt d'au revoir de beaucoup d'infirmières en se quittant à la fin du congrès. La raison? L'Association des Infirmières Enregistrées de la Nouvelle-Ecosse a invité l'AIC à tenir son 30ième congrès biennal à Halifax.

Le Comité Exécutif de l'AIC a aussi été invité à aller tenir l'assemblée suivant immédiatement le congrès, à l'Ile du Prince-Edouard. Au revoir donc à Halifax en 1960!

Projet-Essai

L'inspection de quatre écoles d'infirmières participant au projet d'évaluation des écoles d'infirmières est à peu près terminée. L'on croit qu'au mois de mars 1959, les 25 écoles comprises dans le projet auront été visitées.

Le Bureau de Revision, responsable de l'examen de tous les rapports d'inspection, se réunira probablement vers la mi-octobre.

Plan de Pension devenu réalité

Le plan de pension, tel que recommandé

"Best Medicine A Man Ever Had...?"



Everybody knows the answer—a pretty nurse! Yet Nursing is a profession in which even natural loveliness needs extra-special care.

Constant exposure to infection prompts you to scrub your hands many times during your daily tour of duty... but what about your face? At the end of the day you can give it the extra care it needs quickly and easily with a "Noxzema Wash". Noxzema gives your skin a thorough, *antiseptic* cleansing and an exhilarating facial treatment all at the same time.

You "Noxzema Wash" your face almost as you would wash with soap. Just splash on warm water... and smooth on Noxzema. Then massage Noxzema well into your skin with a wet face cloth and rinse clean. (Greaseless Noxzema dissolves in water.)

Your face tingles and glows... feels refreshed. There's no dry, tight feeling such as you get with even the mildest soaps. There's no heavy, oily film to collect dirt and clog pores such as you get with too greasy creams. Noxzema owes its creaminess to "suspended moisture". This moisture helps replenish the natural moisture of your skin... leaving it fresher, lovelier.

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par le Comité Exécutif de l'AIC fut accepté à l'assemblée générale de juin.

Ce plan de retraite est semblable à celui adopté par l'Association Médicale Canadienne. Il sera à la disposition des infirmières employées dans les hôpitaux ou les services d'hygiène publique de même qu'à celles qui travaillent individuellement. Une partie du plan comporte la participation employeur-employée.

La National Life Insurance et le Royal Trust assumeront l'administration des plans et sont à préparer un livret de renseignements qui sera distribué, par l'entremise des associations provinciales, à tous les membres de l'Association des Infirmières Canadiennes. L'inscription des membres désirant participer à ce plan sera faite au secrétariat national de l'AIC.

Résultat des Elections

Les dignitaires de la prochaine période biennale sont les suivantes: Mlle Alice Girard, présidente; Mlle Helen Carpenter, première vice-présidente et convocatrice du comité de finance; Mlle E. A. Electa MacLennan, deuxième vice-présidente et convocatrice du comité de législation et des règlements; Mlle Hazel Keeler, troisième vice-présidente et convocatrice du comité de l'éducation en nursing.

La révérende Sr. M. Felicitas occupera le poste de convocatrice du comité du service d'infirmières. La nomination de la convocatrice du comité des relations extérieures n'a pas encore été faite.

Les religieuses dont les noms suivent ont été élues membres du comité exécutif: Rév. Sr. Madeleine de Jésus, Ottawa; Rév. Sr. M. Felicitas, Montréal; Rév. Sr. M. Irene, Charlottetown; Rév. Sr. Laurentia, Moose Jaw.

Don pour la résidence de l'AIC

Il a été convenu d'établir un fonds en vue de la future résidence de l'AIC que l'on espère pouvoir habiter d'ici quelques années.

Un don a déjà été reçu à cet effet, du Victorian Order of Nurses du Canada qui a offert à l'AIC deux magnifiques cendriers en argent, gravés des initiales CNA.

Ce cadeau a été reçu avec grand plaisir et nous anticipons le jour de l'inauguration de notre maison alors que nous pourrons les mettre en vue.

Rapport du congrès

Un rapport de l'assemblée générale qui a marqué le 50ième anniversaire de l'AIC est en voie de préparation, dans les deux langues. Nous croyons que le coût en sera d'environ $2.00. On pourra se le procurer en s'adressant à

L'Association des Infirmières Canadiennes
270 ouest, avenue Laurier,
Ottawa, Ont.

Resolutions Passed at the 29th General Meeting Canadian Nurses' Association

Resolution 1

In view of the need for professional nurses equipped to give leadership in research,

Resolved, That the Canadian Nurses' Association go on record as feeling the urgent need for the establishment of postbaccalaureate degree work in connection with one or more University Schools of Nursing in Canada.

Resolution 2

In view of the startling statistics regarding accidents occurring in the areas where nurses share responsibility and

As accidents are the major cause of death and morbidity, we need to attack the problem just as we concentrated on tuberculosis and infant deaths in earlier years,

Resolved, That the Canadian Nurses' Association go on record as being willing to participate with related groups in studies which might be made in the area of accident prevention.

Resolution 3

WHEREAS, There is a definite need to make known the nursing studies and research projects now being undertaken in many parts of Canada and in many branches of nursing, and

WHEREAS, There is need to promote



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further specific studies and coordinate the findings of these,

Resolved, That the national committees on Nursing Service and Nursing Education be responsible for:

1. Compiling a list of the projects completed, or nearing completion, or now being planned by health agencies, such a list to include the title of the study, the agency involved and a brief summary of the method used and the findings, if completed.
2. Suggesting to selected hospitals and other health agencies, studies which should be undertaken, and possible resources at the local, provincial and national levels.
3. Sponsoring the publication of the list of studies from time to time in *The Canadian Nurse* or other appropriate periodicals and promoting the publication and distribution of selected studies in the form of a brochure.

Resolution 4

WHEREAS, National hospital insurance is increasing the demand for nursing service in hospitals, public health and home service, and
WHEREAS, It is imperative that more nurses be prepared for teaching, supervision, administration and public health nursing, and
WHEREAS, The money now allotted to bursaries for nurses under the professional training grant is not sufficient to meet the demands for financial assistance from worthy applicants, and
WHEREAS, Salaries of nurses have not kept pace with rising costs of living and increased costs of university education,

Resolved, That the Department of National Health and Welfare be requested to make more bursaries available to nurses, to increase the amounts of individual bursaries, and to permit students to attend the university of their choice.

Resolution 5

WHEREAS, The Canadian Nurses' Association is presently conducting a Pilot Project on the Evaluation of Schools of Nursing in Canada,

Resolved, That the Committee on Nursing Education of the Canadian Nurses' Association give leadership as early as possible in the 1958-60 biennium, to the Committees on Education of the provincial Registered Nurses' Associations in a study by the membership, of the objectives, tools and procedures which are being used in conducting the Pilot Project for Evaluation of Schools of Nursing in Canada.

Resolution 6

WHEREAS, 1958 marks the Fiftieth Anniversary year of the Canadian Nurses' Association, an organization looking forward to marked growth in the next fifty years and
WHEREAS, The Committee on Finance in its Biennial Report has indicated its desire to establish a special fund for a new national headquarters — our own CNA House,

Resolved, That this Convention go on record as supporting the desire of the Committee on Finance to set up a Special Fund for establishing our own national headquarters and that the Executive be empowered to take under consideration ways and means of accomplishing this objective with the least possible delay.

Resolution 7

Resolved, that the Canadian Nurses' Association adopt the Pension Plan as presented to this biennial meeting.

Resolution 8

WHEREAS, A Canadian Student Nurses' Association would provide unity and a mutual exchange of ideas and common problems on a national level, and
WHEREAS, The provincial student nurses' associations have proven successful in dealing with this aforesaid, and
WHEREAS, A Canadian Student Nurses' Association would provide opportunities for aiding the Canadian Nurses' Association in such projects as the Pilot Project and
WHEREAS, A Canadian Student Nurses' Association would indirectly prepare student nurses to accept their responsibility as graduate nurses in the Canadian Nurses' Association and
WHEREAS, 1958 being the 50th Anniversary of the Canadian Nurses' Association this year would be most appropriate for the inauguration of a Canadian Student Nurses' Association.

Resolved, That the Executive of the Canadian Nurses' Association review the former recommendation to establish a Canadian Student Nurses' Association.

University College Hospital of the West Indies

A Nurses' League of the University College Hospital of the West Indies is being formed to enable all graduate nurses of the Hospital to keep in touch with their training school, and to form a link between past and present nurses. All graduates who are interested in becoming members of the League are asked to send their names and present addresses to Matron for further information.

It is planned to publish a magazine each year containing names, addresses and news of all members, and to have an annual reunion at the Hospital. Graduates of the University College Hospital of the West Indies may also be interested in knowing that their hospital now has its own distinctive badge. The cost of the badge engraved with name and date of graduation is 31/-, plus 1/6 to cover cost of packing and registering for post.

Requests for badges should be sent together with your full name, date of training and a postal order or cheque to cover cost, to Matron, University College Hospital, Mona, St. Andrew, Jamaica, B.W.I.

Book Reviews

Communication for Nurses by Florence K. Lockerby, A.B., M.A. 175 pages. The C. V. Mosby Company, St. Louis, Mo. 1958. Price $3.75.

Soon after they learned to walk, sometimes before, girl babies, who will later become student nurses, learned to talk. Most of them have practised this gift lavishly before they enter a school of nursing. Too many of them become strangely tongue-tied when confronted by the need to express themselves clearly, intelligently and succinctly in the course of their nursing duties. They may flounder in an effort to phrase questions in such a way that they will receive the information they are seeking.

Many do not realize that the ability to listen and comprehend is an equally important aspect of communication. They look without really seeing, they listen but do not

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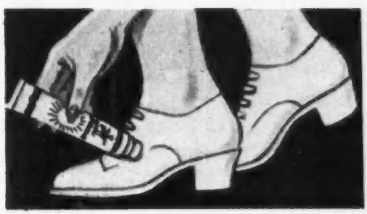
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understand the true significance of what they hear. How can the nurse learn to listen effectively, to handle serious conversation intelligently, to observe and interpret what she sees in the best interests of her patients? How can she make her concisely charted notes convey a true picture of the patients' conditions, needs and reactions?

This book is the outcome of a new course that is being introduced into the curriculum of many schools of nursing. It is essentially a textbook for the students, providing helpful information that they may learn to adapt to their own needs from the beginning of their preclinical period. Graduate nurses, too, would benefit from the practice of the skills that are discussed. The mental image of a nurses' convention where every member is able to express her thoughts successfully is very stimulating.

Services for Children with Hearing Impairment. Prepared by the Committee on Child Health of the American Public Health Association. 120 pages. The American Public Health Association, Inc., 1790 Broadway, New York 19, N.Y.

Reviewed by Miss Christene Miller, School Nurse, Protestant Central School Board of the County of Brome, Knowlton, P.Q.

This book is a series of guides to services for handicapped children. It deals with problems common to various handicapping conditions, discusses the general philosophy of community services for handicapped children, and outlines principles and practices on which programs may be based. It should be of particular interest to school nurses and public health nurses working with preschool and school age children.

What impaired hearing means to the child in its various forms of severity from mild impairment to deafness is clearly defined. Listening and talking are so much a part of everyday life that most of us take them for granted. It is difficult to conceive of a world in which some or all sounds are blotted out or distorted.

Case finding goes beyond the narrow concept of merely locating a child who is deaf or hard of hearing. It is also concerned with recognizing children who have potential ear trouble or hearing impairment in order that disability may be prevented. It implies being alert to the continuing and changing needs of children who are known to be handicapped by hearing loss. The comprehensive appraisal of a hearing problem has several phases. It usually requires several types of professional services. The medical evaluation by an otologist is often supplemented with further testing, frequently carried out by a neurologist or by paramedical personnel with the necessary training in audiology, audiometry, or speech pathology.

Rehabilitation of a child with a hearing problem may be relatively simple, clear-cut and inexpensive. Frequently it is very difficult, time-consuming and expensive, involving auditory training, lip reading and speech training. In some instances it may require special schooling particularly in the case of the child who has very little or no auditory sound perception. The emotional and adjustment problems that children with impaired hearing may have to face are varied. Many of them will require hearing aids or other type of special equipment. These children may need help in accepting their special status. Children with severe hearing loss tend to feel isolated and left out. Those who are withdrawn and insecure need guidance in their personal relationship with other children and adults and in finding constructive outlets through community activities.

Social, financial, and environmental difficulties may present serious problems to some families. Here social services can assume responsibility. They can ensure wise use of community resources by acting as liaison between the family and the agencies whose services are needed.

A logical first step in setting up a community program for hearing conservation would be to determine community needs and resources. The family physician, school teacher, public health nurse, school physician and other local personnel are at the heart of any successful community hearing program.

An excellent appendix gives concise definitions of types of hearing impairment, and indicates the value of certain audiometric screening tests. This is certainly a very worthwhile book for any nurse interested in or concerned with hearing problems.

Nursing Care of the Surgical Patient by John Pettit West, M.D., Manelva Wylie Keller, B.S., R.N., and Elizabeth H. Harmon, M.A., R.N. 606 pages. The Macmillan Company, New York. Brett-Macmillan Limited, 132 Water St. S., Galt, Ont. 6th Ed. 1957. Price $5.75.

Reviewed by Miss Evelyn M. Paul, Associate Director in charge of Education, Cornwall General Hospital, Ont.

The objective of the authors to provide a text for the basic nursing student that would discuss general principles of surgical nursing

care that could be adapted to the individual patient's needs, seems to have been attained.

The subject matter is basic. Barriers of allied sciences have been crossed to reveal fundamental relationships as they exist in the care of the average patient. Illustrations and diagrams are not as numerous as in some texts but definitions are concise, simply stated and understandable. The nomenclature includes the terms most commonly encountered in the general nursing course.

The human element is not omitted. Psychological aspects are discussed. The importance of emotional factors pre- and postoperatively have been adequately dealt with without becoming too involved in unusual situations.

Questions at the end of each chapter are thought-provoking and should stimulate the student to further investigation and research. Suggested reading lists following the questions are extensive. They include many periodicals found in most school libraries.

Student nurses would benefit most from this text, but nurses employed in surgical units would find it good refresher material. Instructors would find it a useful reference text.

Post-Basic Nursing Education by Yvonne Schroeder assisted by the staff of The Florence Nightingale International Foundation. Vol. I — 111 pages; Vol. II — 74 pages. The International Council of Nurses, 1 Dean Trench St., Westminster, London, S.W.1, England. Price — Vol. I, $3.75; Vol. II, $1.50.

Reviewed by Miss Rae Chittick, Director, McGill School for Graduate Nurses, Montreal.

It has long been recognized that additional preparation beyond that of the basic nursing education program is essential for nurses working in special fields and particularly for teachers and administrators. In 1899 Teachers College, Columbia University, initiated the first college program for graduate nurses. Since that time many universities in different countries have developed various types of post-basic educational programs to meet their particular needs. Since one of the functions of the World Health Organization is to assist countries to meet their need for well-prepared personnel, they requested the ICN to study advanced programs in nursing education in their member countries and to publish the results of their findings. This Report is the third in the series.

In carrying out this study Miss Schroeder has been guided by suggestions from nursing

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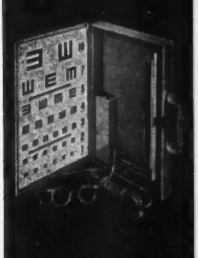
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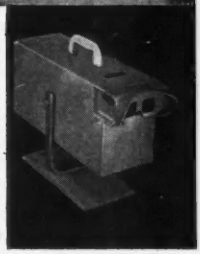
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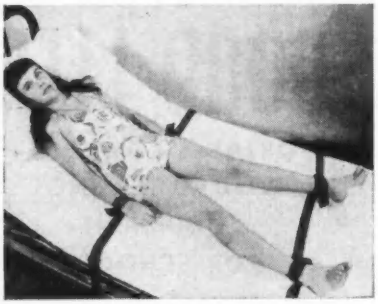
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experts and consultants in many parts of the world. The over-all aim of the study is to develop guidelines for the establishment, development and revision of advanced programs in nursing. The generally accepted principles of administration are the framework for the study and data are assembled around these principles. The information was collected by means of a carefully compiled questionnaire that was circulated to institutions conducting post-basic educational courses of more than six months in length. Ninety-eight questionnaires representing 22 countries were returned.

The report of this study is published in two volumes. The first volume gives the purposes and the methodology of the study, discusses the influence of cultural, social and economic factors on the administration of advanced programs in nursing education, and contains the guide for the administration of advanced programs. The second volume assembles the data collected from the questionnaires and analyzes the findings in respect to each of the principles of administration. No attempt has been made to evaluate the education programs, but in discussing the replies to questions the authors have pointed up the difficulties associated with the application of principles in various situations.

Although the Report was prepared to assist nursing educators to evaluate their programs for graduate nurses, administrators in all branches of nursing will find the Report invaluable. The basic principles of administration that are set down here and discussed so clearly and succinctly are essential to good administration at all levels and in all fields of nursing. No administrator can read this Report without being stimulated to develop the implications of these principles for her own particular situation whether she is working in a university, hospital or public health agency.

Midwifery: Principles and Practice for Pupil Midwives, Teacher Midwives and Obstetric Dressers by R. Christie Brown, M.B., M.S., F.R.C.S., F.R.C.O.G., Barton Gilbert, B.Sc., M.D., F.R.C.S., F.R.C.O.G., Donald B. Fraser, B.M., B.Ch., F.R.C.S., F.R.C.O.G., Richard H. Dodds, M.D., F.R.C.P. The Macmillan Company of Canada, Ltd., 70 Bond Street, Toronto 1. 892 pages. 4th Ed. 1956. Price $4.25.

Reviewed by Miss A. C. Dunnett, Union Hospital, Moose Jaw, Sask.

This is an excellent manual for maternity nurses. The authors have combined their knowledge of obstetrics and have produced a concise, interesting, and easily read textbook for both student and graduate nurses.

The introductory section differs from the usual text, in that it contains several chapters on elementary scientific principles and their application to midwifery. Most of the up-to-date trends in the obstetrical field can be found in this manual. It is quite suitable not only as a study text but also as an excellent library reference.

Normal obstetrics is particularly well described. The chapter on antepartum hemorrhage is extremely well illustrated. Rh incompatibility has been clearly and adequately explained although the relationships of the hereditary factors have been omitted. On the whole, this is a textbook of great value in the study of obstetrics.

News Notes

ALBERTA

CALGARY

Eighteen members attended a recent chapter meeting held at the Associate Clinic. Thanks to special planning by this group, student and graduate nurse delegates were given a lively farewell before leaving to attend the CNA convention in Ottawa. Miss Bibby gave an interesting account of the provincial convention held earlier this year.

MEDICINE HAT

Twenty-seven members attended a recent chapter meeting and heard the reports of their delegates to the annual provincial convention. Miss R. Ziehran is the general convener of the Harvest Tea which is to be held September 27.

EDMONTON

General Hospital

G. Graves attended the American Nurses' Association convention and the Catholic School of Nursing convention recently. Both conventions were held in Atlantic City. Sr. A. Bonin, R. O'Byrne and two student nurses attended the CNA convention in Ottawa. Representatives from nursing service, members of the faculty and six students attended the annual provincial convention in Banff. Two members of the faculty participated in a panel on clinical teaching. H. Kuchaba and T. Ryan are attending summer school in Spokane, Washington.

A lawn party preceded the departure of all the various staff members to their respective conventions and summer school. A gift was presented to Mrs. Currie, pediatric clinical instructor, on the same occasion in appreciation of her services.

HINTON

The third meeting of this chapter since its organizational meeting had 12 members in attendance. M. Ries presented her report as delegate to the annual A.A.R.N. convention. Dr. Tak Hayashi was the guest speaker and gave a most interesting and educational illustrated talk on dental hygiene. The numerous questions put to him by his audience testified to the keen interest in this subject.

Chapter members were responsible for a booth at the events in connection with the Timber Festival held early in August. In addition to a display of material on health education, a First Aid station was supplied. A drawing for a car first aid kit proved to be a successful means of raising funds. M.

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Ries resigned from her job in July, and T. Piwek took over the position of secretary-treasurer for the chapter.

JASPER

A recent chapter meeting became a farewell party for two popular members — Mrs. Gates and Mrs. McCague, chapter president. A pleasant supper party preceded the business session and gifts were presented to both ladies. A committee was formed to contact the School Board in regard to vitamin pills to be made available to school children.

NOVA SCOTIA

HALIFAX

Halifax Infirmary

Approximately 175 nurses from the city and distant points attended the Golden Anniversary reunion of the school of nursing. Two members of the class of '11 — the first graduating class — were present at the anniversary tea. A graduate of 1912 cut the birthday cake presented by the city and displayed at the banquet. Guests attended graduation exercises for the class of '58 when 44 young ladies received their diplomas. Festivities ended with a buffet supper when the nurses were guests of the provincial government. Arrangements for this very pleasant reunion were directed by Mmes J. Grant and J. Gow.

The following is the slate of alumnae officers for the current year: Pres., Mrs. J. Gow; vice-pres., S. Mason; rec. sec., E. Terrio; corr. sec., P. Tobin; treas., Mrs. M. O'Leary; sick visiting, C. MacDonald; ways & means, A. Horne; entertainment, M. Hope.

Victoria General Hospital

Reviewing its activities for the past year, the alumnae association reported an interesting and profitable season. A tea and sale were a feature of the Christmas meeting in 1957. A successful bridge party was held for members and their friends during the early part of this year. In April Dr. N. H. Gosse, president of the Canadian Medical Association, was the guest speaker. He showed pictures taken during his trip to Istanbul as a delegate to the World Medical Association congress. Dr. Gosse emphasized the



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striking points in the architecture, history, mythology and current events of that country. In May, a Mother and Daughter Tea was held in honor of the 76 members of the graduating class.

The officers for the current year are: Pres., G. Flick; vice-pres., P. Redden, Mrs. D. Luscombe; sec., E. Brown; treas., J. Nelson; archivist, M. Graham; program convener, Mrs. E. Manchester; sick and visiting, Mmes E. Gormley, F. MacCullough.

ONTARIO

OWEN SOUND

General and Marine Hospital

The alumnae association entertained the 16 members of the graduating class at a banquet prior to graduating exercises. Each girl received a class pin as a gift from the association. An award of $25 was made to the student who showed greatest progress during training. A reception and formal dance followed the exercises which were held on the lawn of the hospital. The graduating students were guests of honor at the annual association picnic. Films of previous graduating ceremonies were shown.

DISTRICT 5

TORONTO

General Hospital

J. Taylor who obtained her Bachelor of Nursing degree from the McGill School for Graduate Nurses this year, has accepted a position with WHO. She has been posted to Khartoum, Sudan. S. Goard is working in the hospital at Lindsay, Ont. M. Brillinger is working in the Albert Schweitzer Hospital, Haiti. E. Simpson Thompson is working as a nursing supervisor at Glendale Memorial Hospital, California. L. Sato has joined the teaching staff of her home hospital as a clinical instructor. M. Junkin has also returned to the staff after postgraduate study at the University of Toronto. P. Parker has joined the staff of Peterborough Civic Hospital. J. Gauley is working in the nursing office of the hospital. R. Starkey has been appointed matron of the RCAF hospital at Goose Bay, Labrador. B. Roach, F. Wallace and R. Rombough are on the staff of the Calgary General Hospital and I. MacRae is working in the Presbyterian Hospital, New York. B. Gardner and P. McCleary have accepted positions with the T. Eaton Company, Health Service. A. Maksinuk is now the assistant chief stewardess for TCA in the Winnipeg area.

DISTRICT 8

OTTAWA

Lady Stanley Institute

Alumnae members assembled recently at the home of Dr. and Mrs. Caven to honor Miss Mabel Stewart who is retiring from her position as superintendent of the Royal Ottawa Sanitorium. Mrs. C. Port, president and Mrs. Caven received the guests. Mrs. A. Cram and Mrs. J. Howe presided at the tea table. A gift was presented to the guest of honor on behalf of the alumnae members by Miss McNiece and Mrs. Ritchie.

The Board of Trustees of the Sanitorium also entertained Miss Stewart on another occasion. She received an engraved silver tray.

Miss Stewart has given years of loyal service to her profession. Her friends and colleagues wish her many years of happiness in her new life.

QUEBEC

MONTREAL

Royal Victoria Hospital

Mary Lockhart has been in charge of the health service at the Calgary General Hospital for the past year. Adele Peterson who is with the Indian Health Service in Saskatchewan, plans to attend the University of Toronto this fall. Shirley Dawson is an instructor in nursing at the Ontario Hospital, Kingston. Stella McVicar is a nursing sister with the RCAF at North Bay. Joan Timmins is on the staff of the Presbyterian Hospital, New York, and is also working towards her nursing degree at Columbia University. Lois Conway is with the RCAF at Senneterre, P.Q.



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Hospital Superintendent (Duties to commence June 15, 1958) for modern 28-bed hospital, Supervisory ability necessary. Excellent living quarters. Apply stating references, age, experience & salary expected to: Mrs. M. S. Leslie, Secretary, The Executive Committee, Bingham Memorial Hospital, Matheson, Ontario.

Director of Nursing for 300-bed pediatric hospital at The Montreal Children's Hospital — Affiliated with McGill University — No School of Nursing here at present. Age 30-45. Pediatric training preferred. Degree in nursing preferred but not essential. Apply to Executive Director, The Montreal Children's Hospital, 2300 Tupper Street, Montreal, Que.

Matron for 12-bed hospital. $325-Month gross. 40-hr. wk. Accommodation available. Apply to Secretary-Treasurer, Canmore Municipal Hospital, Canmore, Alberta.

Matron (1) with knowledge of X-Ray; **General Duty Nurses (2)** required immediately for 18-bed hospital. 40-hr. wk. statutory holidays & regular vacation. Room & Board $30 per mo. Beautiful location. Apply with full details, salary expected. Administrator, Arrow Lakes Hospital, Nakusp, British Columbia.

Matron with administrative experience for 53-bed, modern hospital — fully staffed. Finest equipment; X-ray Lab with technician. Salary $350-$380 with increments. Private suite in fully modern nurses residence. Complete maintenance, $35 per mo. Situated in the prettiest town in Southern Manitoba, excellent transportation. Write or phone Chairman of the Hospital Board, or Secretary, Morden District General Hospital, Morden, Manitoba.

Assistant Matron with postgraduate preparation for 140-bed hospital with building program in operation. For further information, write Acting Matron, King Edward VII Memorial Hospital, Bermuda.

Superintendent for 35-bed hospital 50 mi. from Toronto, living accommodation in residence. For further particulars apply to F. S. Hackett, Secretary-Treasurer, The Stevenson Memorial Hospital, Box 251, Alliston, Ontario.

Assistant Superintendent and General Duty Nurses, for well-equipped 47-bed hospital. 8-hr. duty, 5½-day wk. Annual vacation with pay. Statutory holidays. Full maintenance in new modern residence. For further information apply: Superintendent, General Hospital, Kincardine, Ontario.

Administrative Supervisor — Pediatric Dept. 30-bed unit in modern hospital; good personnel policies. Apply: Director of Nursing, Civic Hospital, Peterborough, Ontario.

Nursing Supervisor for small hospital in Northwest Territories. Good wages & living conditions. Apply stating training & experience to Superintendent, Yellowknife District Hospital, Yellowknife, N.W.T.

Night Supervisor, Head Nurse (Pediatrics), General Duty Nurses & Nursing Assistants. Salaries $300 — $385, $280 — $360, $250 — $320, $170 — $200 respectively. For full particulars please write to — The Director of Nurses, Swift Current Union Hospital, Swift Current, Saskatchewan.

Assistant Night Supervisor — Head Nurses for Medical & Surgical Wards — **General Duty Nurses** for 450-bed hospital with training school. Excellent personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

Operating Room Supervisor for 110-bed modern hospital; excellent personnel policies. Apply: Superintendent, Charlotte County Hospital; St. Stephen, New Brunswick.

Operating Room Supervisor for large Sanatorium. Experience in Chest Surgery desirable. Salary according to qualifications. Good personnel policies. Apply Director of Nursing Service. The Beck Memorial Sanatorium, London, Ontario.

Operating Room Supervisor, Night Supervisor, Assistant Head Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

Obstetrical Supervisor for 25-bed department in 120-bed JCAH approved community hospital. Brochure on hospital, community & policies furnished on request. Call or write Director of Nurses, Northwestern Hospital, Thief River Falls, Minnesota.

Director of Nursing Education for 500-bed general hospital with a school of nursing. Applicant must have a degree in nursing. Salary commensurate with experience & qualifications. Apply to, Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

Nursing Arts Instructor — To teach fundamentals of Nursing & assist with Medical-Surgical Nursing by September 1, 1958. School of Nursing, 80 students — 1 class per year — 40-hr. wk. Salary as recommended by R.N.A. of Nova Scotia, good personnel policies. Apply: Superintendent, General Hospital, Glace Bay, Nova Scotia.

Clinical Instructor for well baby nurseries. State qualifications, experience & references. Apply: Director of Nursing, Women's College Hospital, Toronto 5, Ontario.

Clinical Instructor-Medical-Surgical Nursing — 40 students 1 class a yr. 40-hr. wk. For further information please apply Director of Nursing, Yorkton General Hospital, Yorkton, Saskatchewan.

Head Nurse to be in complete charge of 10-bed hospital — 120-mi. from Winnipeg — good bus service — Salary $300 will be increased to $310 January 1, 1959, less maintenance $30. Apply to Mr. J. F. Anderson, Secretary-Treasurer, Siglunes Medical Nursing Unit, Ashern, Manitoba.

Head Nurses for 48-bed general hospital. Starting salary $350 with regular increments, 40-hr. wk. 8 holidays per yr. Group Hospital & Life insurance, Social Security. Accredited, air-conditioned. well-equipped 7-yr. old hospital located in the heart of the San Joaquin Valley, close to the mountains & beaches. Apply to (enclose picture) (Miss) Alma P. Kauffman, R.N. Director of Nurses, West Side Hospital District, 110 E. North St., Taft, California.

Infirmières Licenciées (6) pour service général — sont désirées à l'Hôpital (52 lits). Les salaires: $240-$275 selon l'expérience. Service de 40 heures, sans service de nuit. 3 semaines de vacances payées, après un an de service, en plus des 10 jours durant l'année. Veuillez adresser toute correspondance: Les Soeurs de la Charité de N.D. d'Evron, Hôpital St. Louis, Bonnyville, Alberta.

Registered Nurses (6) for 52-bed hospital. Salary: $240-$275, according to experience. 5-day wk. No night shift. 3-wk. vacation with pay, after 1-yr. service. Apply: Superintendent, St. Louis Hospital, Bonnyville, Alberta.

Registered Nurses and trained Nursing Aides needed for a large expanding City Hospital in Edmonton, Alberta. **General Duty** $240 - $270 per mo. plus laundry; **Staff Nurses** $270 - $300 per mo. plus laundry; **Certified Nursing Aides** $168 - $189 per mo. plus laundry. Experience available in all departments including Operating Rooms & Case Rooms. Credit given for postgraduate work & past experience. Opportunities for advancement. Liberal sick leave & vacation allowances. 40-hr. wk. For particulars apply to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Registered Nurses (2) for 17-bed hospital; general duty; salary $240 gross with annual increments to $270. 44-hr. wk. 1-mo. vacation after 1-yr. Transportation refunded after 6-mo. service. Apply: Elnora Municipal Hospital, Elnora, Alberta.

Registered Nurses for General Duty immediately, in 19-bed hospital located 95-mi. southwest of Edmonton. Close to three (3) summer resorts this oil town offers many varied entertainments. There is daily bus & train service to other points in the province. Starting wages are $220 per mo. plus maintenance with a $5 increase every 6-mo. For further information please write or phone, The Matron, Rimbey Municipal Hospital, Rimbey, Alta.

Registered Nurses (2) for general duty, B.C.R.N.A. policies in effect. Apply: Matron, Creston Valley Hospital, Creston, British Columbia.

Registered Nurses (2) for 16-bed modern hospital salary $260 per mo. gross, $5 increments each 6-mo. for 4 increases, 8-hr. day, 44-hr. wk. 3 wk. vacation with pay after 1-yr. service plus statutory holidays, living quarters in hospital. Apply: Secretary or Matron, Wilson Memorial Hospital, Melita, Manitoba.

Registered General Duty Nurses salary minimum $250 maximum $284; evening duty additional $10 and **Licensed Practical Nurses** salary minimum $194 maximum $215. 40-hr. wk. statutory holidays, liberal sick time, pension plan, holiday allowance, accommodation available in Nurses' Residence, uniforms laundered free. Must qualify for Manitoba registration. Apply: Director of Nursing, Winnipeg Municipal Hospitals, Morley Avenue East, Winnipeg 13. Manitoba.

Registered Nurses: for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses for general duty in 44-bed hospital situated in the Niagara Peninsula. For salary rates & personnel policies, apply: Director of Nursing, Haldimand War Memorial Hospital, Dunnville, Ontario.

Registered Nurses for General Duty. Salary range $235-$265 depending on qualifications. Residence accommodation available. 74-bed general hospital on beautiful Lake of the Woods. Forward enquiries to Superintendent, Kenora General Hospital, Kenora, Ontario.

Registered Nurses for general duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses & Certified Nursing Assistants for new expanding 88-bed hospital in a pleasant progressive town. **General Duty Registered Nurses** start $220, annual increments to $240, **Certified Nursing Assistants** $150, annual increments to $180. 2-wk. shift rotation, bonus for 4-12 & 12-8 shifts. Accumulated sick leave to 60-dy. Only 1-hr. drive to Toronto, to other cities & resort areas. Local swimming pool, artificial ice arena, bowling, etc. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for medical, surgical, obstetrical, pediatric & geriatric departments. Gross salary: $235, with annual increments. 5-day wk., 8-hr. day. 21-day vacation 1st & 2nd yr. 28-day, 3rd yr. Sick leave accumulative to 60 days. Transportation up to $50 paid after 1 yr. service. Community hospital in lake area. Apply: Director of Nursing, General Hospital, Port Arthur, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses (2) for general staff duty in 8-bed hospital. Employee benefits include a 5-dy. wk. salary range from $260-$320 per mo. according to experience. Full maintenance available at $30 per mo. For further particulars contact Mrs. M. E. Rumpel, Secretary-Treasurer, Hodgeville Union Hospital, Hodgeville, Saskatchewan.

Registered or Graduate Nurses (4) for general duty in 45-bed hospital in town of 3000 pop. Salary $250 per mo. less maintenance of $30 per mo. $5.00 increments every 6-mo. Travel allowance of $50 refunded after 1-yr. of service. Duties to commence as soon as possible. For further information apply, Matron, Meadow Lake Union Hospital, Meadow Lake, Sask.

Registered Nurse for small hospital in North. Apply: Matron, Yellowknife District Hospital, Yellowknife, N.W.T.

Registered Nurses & Licensed Practical Nurses Attention: Immediate openings on Medical, Surgical, Pediatric floors for nurses. Excellent working conditions in 4-yr. old hospital located in good residential section of an American resort city. Top rate of pay with sick pay benefits, liberal vacation plan, hospital paid pension plan & other fringe benefits. Write today to Box B, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Que. giving full resume first letter.

Registered Nurses & O.R. Nurse for modern 60-bed general hospital 40-mi. south of Montreal. Salary $210 per mo. $5. increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts, 44-hr. wk. Many attractive benefits. Board & accommodation available at minimum cost in new motel-style nurses' residence. Apply: Supt. Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days; paid vacation; 7 paid holidays; sick leave. Surgery starting base pay $338 stand by & call back time extra. **Staff R.N.** starting pay $322 monthly; regular pay increases; P.M. & night differential $10. Apply: Yolo General Hospital, P.O. Box 210, Woodland, California.

Registered Nurses (4) good nurses for general duty, 70-bed hospital, starting salary $300 per mo. with merit increases. one (1) meal furnished while on duty. Living quarters available on hospital property. Nice friendly little town of 4500 population. Two (2) shows, 9 denominational churches. Near public swimming pool, library, West Palm Beach & Fort Myers beaches. Climate ideal. Summer breeze from Lake Okeechobee, largest fresh water lake in United States. If interested, contact Mrs. Anna Mae Jones, Administrator, Henry County Hospital, Clewiston, Florida.

Registered Nurses & Licensed Practical Nurses (Male & Female) staff positions available on general staff & special departments for 250-bed nonsectarian hospital located on beautiful Allison Island, Miami Beach, Florida. Accommodations for living-in available. Apply: Director of Nursing Service, St. Francis Hospital, Inc., Miami Beach 41, Florida.

Registered Nurses-Head Nurses for new & modern hospital offering an opportunity for nursing participation in a dynamic physical & medical rehabilitation program. **Salary Range: Registered Nurses** — $3,580 — $4,610; **Head Nurses** — $3,832 — $4,850. Maximum reached in five (5) years. 40-hr. wk., sick & vacation leaves plus 12 legal holidays, State civil service; retirement plan & social security, free laundry service for uniforms. Rooms available at $12-$16 monthly. If registered in home Province, can in most instances obtain Maryland license through reciprocity. Apply: Superintendent, Montebello Hospital, Baltimore 18, Maryland.

Registered Nurses for 88-bed voluntary non-profit hospital in Community of 11,000. Basic salary $295 per mo. with increments of $5 every 6-mo. up to 2-yr.; 40-hr. wk.; 7 paid holidays; sick leave accumulative to 36-dy. Address inquiries to: Director of Nurses, St. John's Hospital, Red Wing, Minnesota.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $240 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses & Certified Nursing Assistants for new 58-bed hospital. Situated in North Western Ontario. Gross Salary $249 per mo. & $184 per mo., subject to increase after 6-mos. with regular annual increases thereafter. $45 per mo. room & board. Rail fare refunded after one year. New 21-bed nurses' residence-single rooms. Apply; stating age & when available to Director of Nursing, District General Hospital, Dryden, Ont.

General Duty Registered Nurses for 100-bed general hospital in town of 6000 on the shore of Lake Huron. Good personnel policies, residence accommodation available. Apply: Superintendent, Alexandra Marine & General Hospital, Goderich, Ontario.

Registered General Duty Nurses for 28-bed General Hospital. Good salary & personnel policies 44-hr. wk. Adjacent attractive residence, recreation facilities. For further information please apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

Registered General Duty Nurses for County Hospital 45 mi. from center of Montreal with excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, bowling, curling & dancing. 8-mi. from summer resort on Lake St. Francis & 12-mi. from U.S. border. Gross salary: $215 per mo. Three $5.00 increases at 6-mo. intervals to maximum $230. 44-hr. wk. 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 1-mo. annual vacation, all statutory holidays. 2-wk. sick leave. Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Quebec.

Registered General Staff Nurses (6) starting salary $255-$325. **Trained Nurses' Assistants (4)** starting salary $165-$200 for an accredited 75-bed hospital 40-hr. wk., yearly increment — full maintenance $35 — Personnel practices in accordance with S.R.N.A. policies. Apply: Superintendent, St. Therese Hospital, Tisdale, Saskatchewan.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses (3) required immediately for new 54-bed hospital. Gross salary $255 per mo. with annual increase, less $26 maintenance. Group pension; medical & hospitalization plan; 44-hr. wk. 3-wks. vacation after 1-yr. service, plus 10 statutory holidays. Apply stating training; experience & references to Matron, Vermilion Municipal Hospital. Vermilion, Alberta.

General Duty Nurse (1) for rotating shift (30-bed hospital). Salary: $260 per mo. less $40 for room, board & laundry. 40-hr. work wk. 4-wk. vacation with pay after 1 yr. service. 1½ days sick leave per mo. yearly accumulative. Attractive nurses' home adjoining hospital. Apply: Community Hospital, Grand Forks, British Columbia.

General Duty Nurses for a new hospital in the Fraser Canyon, 100-mi. from Vancouver. Salary $260 — Shift differential, 40-hr. wk.; 10 statutory holidays; 1-mo. annual vacation. Accommodation available in a new nurses' residence. Apply: Director of Nurses, Fraser Canyon Hospital, Hope, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling & skiing. Initial salary: $270. Maintenance, $45. 44-hr. wk. 4-wk. vacation with pay. Comfortable, attractive nurses' residence. Rail fare advanced if necessary. References required. Apply Sacred Heart Hospital, Smithers, British Columbia.

NURSING INSTRUCTRESS

Required to direct new program of training for class of 15 Certified Nursing Assistants in modern, suburban, 125-bed hospital. Salary open.

***Inquire to:* DIRECTOR OF NURSING**

HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST. WESTON, TORONTO 15.

CLINICAL INSTRUCTOR (medicine or surgery)

University postgraduate; for 300-bed accredited general hospital school of nursing (87 students) 1 class annually; 42-hr. wk.; 1-mo. vacation; 8 statutory holidays; sick leave; pension plan.

Apply:

DIRECTOR OF NURSING, ST. THOMAS-ELGIN GENERAL HOSPITAL, ST. THOMAS, ONTARIO.

General Duty Nurses for 28-bed hospital, salary $250 unregistered, $260 B.C. registered, nurses' residence available at nominal rate. Must be qualified to take shifts. For further particulars contact Administrator, Lady Minto Hospital, Ashcroft, B.C.

General Duty Graduate Nurses (2). Salary: $250. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $260-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses: Starting salary $260 — $312, for those with 2 yrs. nursing experience $273, annual increment $13, full maintenance $45 per mo., 10 statutory & 28 annual holidays, 1½ day's sick leave per mo. accumulative indefinitely, very active town, world famous Cariboo cattle country, annual Stampede. Apply: Director of Nurses, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. #18, Portage la Prairie, Manitoba.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses, starting salary $245 per mo., with additional $5 monthly for each yr. of experience since graduation up to 4-yr. Maximum salary $275. Blue Cross coverage paid by hospital. Room & board available in Nurses' Residence. 28-dy. vacation. Transportation costs refunded after 6-mo. employment. Apply: Director of Nursing, Atikokan General Hospital, Atikokan, Ontario.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7 mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $235 per mo. with annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $240 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses. O.R. Scrub Nurse (1). For modern well equipped 100-bed general hospital in friendly community. Gross salary: $240 per month if currently registered in Ontario. 8 hr. rotating shifts. 44 hr. wk. 1 day off 1 wk. and 2 the next. 21 days vacation after 1 yr. 7 legal holidays. Good personnel policies. Apply, Miss Willamene R. Allan, General Hospital, Port Colborne, Ont.

General Duty Nurses for 163-bed Tuberculosis Sanatorium. Good salary & personnel policies. Residence accommodation available. Please apply Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

General Duty Nurses for 100-bed modern hospital in south western Ontario. Please apply to: Director of Nurses, Tillsonburg District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for general hospital in Niagara Peninsula. Residence accommodation available. Presently on 44-hr.-wk. but reverting to 40-hr.-wk. in September. Basic salary $245 both now & in September. 4 annual increments & 3-wks. vacation. Apply: Director of Nursing, Welland County General Hospital, Welland, Ontario.

General Duty Nurses for small general hospital, beginning salary $300 per mo. — $10 differential p.m. & night duty — 38-hr. wk. Living accommodations available. Apply: Sister Superior, St. Ann's Hospital, Juneau, Alaska.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in Nurses' Home, meals at reasonable rates, uniforms laundered without charge. Starting salary $304 per mo. plus shift & service differentials, first increase in 6 mo. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary: $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in psychiatry & pediatrics on a segregated service. Apply Superintendent, Community Hospital, Alamosa, Colorado.

General Duty Nurses for 600-bed teaching hospital in Central California. In-service educational program; Salary $337-396, 40-hr. wk.; 11 holidays annually, retirement & sick leave plan. Differential of $20 per mo. for 3:00-11:00 p.m. shift & $15 per mo. for 11:00 p.m.-7:00 a.m. shift. Write Personnel Director, 732 East Main Street, Stockton, California.

Graduate Nurses for 70-bed General Hospital. Salary $255-$275; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1-yr. Apply: Matron, St. George's Hospital, Alert Bay. British Columbia.

Graduate Nurses: For new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

General Staff Nurses (Immediately) for new 288-bed modern hospital opened in January. School of Nursing with a present enrollment of 53 students. Comfortable nurses' residence. 40-hr. wk. Liberal personnel policies. Please apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Staff Nurses for 250-bed General Hospital, located on the Bay of Quinte; approved School of Nursing; planned In-Service education program; desirable personnel policies. For further information, Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Staff Nurse for 20-bed psychiatric unit in general hospital. State qualifications & references when applying to Director of Nursing, Women's College Hospital, Toronto 5, Ontario.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, Liberal personnel policies. Salary $320-$360. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 170-bed hospital; starting salaries $315-$345 per mo. 40-hr. 5-dy. wk. Positions available in Psychiatry, Operating Room & on Medical-Surgical floors. Call & stand-by time is paid O.R. personnel in addition to salary. Paid hospitalization, life insurance, vacation & many other benefits. Write for brochure to Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48. California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Graduate Staff & Operating Room Nurses 225-bed general hospital, near New York City. Salary $290, including benefits; $30 bonus for evening, $25 for night, extra for call duty. Apply: Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

Pediatric Nurses for 100-bed Pediatric teaching hospital; air conditioned. Good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Operating Room Nurse with postgraduate course, for active operating room in general hospital with School of Nursing. Salary $280 per mo., plus increment for experience. Must be eligible for B.C. registration. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Operating Room Supervisor required immediately. New surgical department under construction, capacity to be doubled. Program includes cardiac surgery and neurosurgery. Preparation in O.R. supervision and management essential. Salary commensurate with preparation and experience. Apply, Director of Nursing, Kingston General Hospital, Kingston, Ont.

Operating Room Nurses for 370-bed approved General Hospital with an intern-resident program. 7 theatres; 650 to 750 cases monthly. Starting salary $330 or $340 per mo. according to experience. $20 per mo. merit increases at 12, 24 & 36 mos. 40-hr. wk. 2-wk paid vacation. Paid sick leave, 7 paid holidays. Resort location in California's finest recreational area. Apply to: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Ave., Long Beach 13, California.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. $375 per mo. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Public Health Nurse for generalized program in mixed urban & rural district. Salary according to experience with annual increments. Usual employee benefits — holiday & sick leave, pension plan, hospital & medical insurance. Transportation provided. Pleasant climate & good working conditions. Apply to Medical Officer of Health, Barons-Eureka Health Unit, Coaldale, Alberta.

Public Health Nurse (qualified). Minimum salary $3,200; allowance for experience, $150 annual increments. 5 dy. wk. 4-wk. vacation, sick leave credits, Blue Cross Pension Plan, car allowance, financial assistance towards purchase of car. Apply to Mr. A. F. Stewart Secretary-Treasurer, Wentworth County Health Unit, Court House, Hamilton, Ontario.

Public Health Nurse for generalized program, including bedside nursing. 1-mo. vacation after 1 yr. Blue Cross & group insurance available. Interest-free loan for purchase of car. Apply: Dr. J. I. Jeffs, Health Unit, Napanee, Ontario.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses for public health nursing in a generalized program, salary based on experience; range $3,309 - $3,867 per annum. Positions carry pension, Blue Cross, medical & surgical care, sick leave & other privileges. Applications will be received by the Local Board of Health, 2090 Wyandotte St. E. Windsor, Ontario.

Graduate Nurse for general duty required immediately. Salary $250 per mo. 40 hr. wk. 28 days vacation after 1 yr. service. 10 statutory holidays. Full maintenance in new, modern nurses' residence, $48 per mo. Fare up to $40 refunded after 1 yr. service. Full information available. Apply, Miss F. Gerwing, Nursing Supervisor, General Hospital, Golden, British Columbia.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Salary: $3,240 to $3,720 per annum. Openings also available for **General Duty Nurses.** Residence with board, if desired, $30 per mo. Excellent holiday, sick leave & pension benefits. Apply to: Superintendent of Nurses.

Certified Nursing Assistants for immediate vacancies in an accredited 64-bed hospital. Starting salary $180 per mo. annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Combined Lab & X-ray Technician for small general hospital — $400 per mo. Apply: Sister Superior, St. Ann's Hospital, Juneau, Alaska.

Registered Laboratory Technician. to take charge of laboratory in a modern 88-bed general hospital. Very pleasant & progressive town, near large cities & resorts. Apply: stating salary expected, to the Administrator, Dufferin Area Hospital, Orangeville, Ontario.

General Duty Nurses (2) for modern 35-bed hospital. Salary $220 per mo. plus full maintenance, 3-$10 per mo. annual increments. 1-mo. holiday pay, 2-wk. sick leave. If employed for 1-yr. a refund of train fare from any point in Canada will be given. Apply to: Two Hills Municipal Hospital, Two Hills, Alberta. Phone 335.

Operating Room & Staff Nurses for 230-bed Tuberculosis Hospital, located in the beautiful Willamette Valley. Starting salary $320; following 6-mo. satisfactory trial service $336; 40-hr. wk. 9 paid holidays a yr. Social Security & retirement benefits, full maintenance $40 a mo. Apply Superintendent of Nurses, Oregon State Tuberculosis Hospital, Route 4, Box 28, Salem, Oregon.

Registered Nurses with experience for 235-bed hospital in northern Ontario. For further information apply to Directress of Nurses, Misericordia Hospital, Haileybury, Ontario.

Director of Nurses for 31-bed hospital in sunny Similkameen Valley on all weather highway to Vancouver. Salary open. 28 days annual vacation. 10 statutory holidays. Self-contained residence. Full maintenance $45 per mo. Apply, Administrator, General Hospital, Princeton. B.C.

Graduate Nurses for new 140-bed hospital: 1. Charge nurse for Central Supply, to open and organize dept. 2. Head nurse for Pediatric dept. 3. Head nurse for men's Medical and Surgical 24-bed dept. 4. Operating Room nurse (1) 5. General duty nurses. Positions 1 to 4 all to have postgraduate courses or equivalent in experience. Salaries and personnel policies in accordance with R.N.A.B.C. Positions open until November 1. Apply, Director of Nursing, General Hospital, Chilliwack, B.C.

Registered Nurses. Salary: $270 plus room and board. 42-hr. wk. Pleasant working conditions. Good personnel policies. Apply, Matron, Municipal Hospital, Mercoal, Alberta.

Registered Nurses for new, modern 640-bed county hospital. Salary: $339-$392 per mo. Excellent working conditions. Liberal sick leave, vacation, retirement benefits. California registration or eligibility for registration required. Apply, Administrator, Kern General Hospital, Bakersfield, California.

Registered Nurse (1) for Margaret Cochenour Memorial Hospital (modern 15-bed) located on the lake in Red Lake mining district & tourist area. New nurses' residence beautifully furnished. Salary: $275 basic with increment plan. Maintenance including uniform laundry, $30 per mo. 44-hr. wk. Holidays. 4-wk. vacation with pay yearly. Transportation expense will be paid after 6-mo. employment. Apply I. MacNaughton, Matron, Cochenour, Ontario.



OFFERS NURSES

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EXPERIENCE and SERVICE

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SURGERY and MEDICINE

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UNIVERSITY HOSPITAL and HILLMAN CLINIC

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BIRMINGHAM 3, ALABAMA

JEWISH GENERAL HOSPITAL

MONTREAL, QUEBEC

(400 BEDS, DECEMBER 1958)

Has senior positions available in Nursing Service Administration & in the School of Nursing as well as vacancies for staff nurses. Excellent personnel policies & salary.

For information, write to

DIRECTOR OF NURSING

JEWISH GENERAL HOSPITAL

3755 COTE ST. CATHERINE ROAD

THE B. C. CIVIL SERVICE

requires

SUPERINTENDENT OF NURSES 3

MENTAL HEALTH SERVICES ESSONDALE

Salary $355 — $420 per mo. Duties include organizing & administering the nursing services for several large nursing units. Applicants must be British subjects & registered or eligible for registration with the Registered Nurses' Association of B.C. In addition, applicants must have a degree or diploma in administration or teaching & supervision & have completed a postgraduate course in psychiatric nursing or equivalent.

For further information & application forms apply to the

PERSONNEL OFFICER, CIVIL SERVICE COMMISSION, ESSONDALE, B.C.

COMPETITION NO: 58:336.

TORONTO GENERAL HOSPITAL

requires

NURSING STAFF

New Building is to open soon. Variety of Opportunities, Valuable Experience in this large teaching centre. Attractive Personnel Policies.

The Toronto General Hospital is opening its new building which contains centralized Operating Rooms; Recovery Rooms; Surgical Supply Service; Obstetrics and Gynecology; Neurology and Neurosurgery; Admitting and Emergency; Rehabilitation and Physical Medicine; Urology and Ophthalmology.

For information write to:

Director of Nursing, Toronto General Hospital, Toronto 2, Ontario.



Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

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COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$350 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

CANADA'S CHEMICAL VALLEY

SARNIA, ONTARIO

DIRECTOR OF NURSING SERVICES

Required for modern, fully approved (JCAH) 300-bed well equipped hospital. This progressive industrial city of 45,000 is growing; it is a summer resort area located on the shores of Lake Huron and the St. Clair River.

The hospital has approved schools for nurses, laboratory technologists, x-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least a Bachelor's degree in administration, and successful experience in the field of nursing education as well as in nursing administration.

For more details and literature concerning the position and Sarnia, write to:

Personnel Director,
Sarnia General Hospital, Sarnia, Ontario.

THE REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

invites applications for two positions, both open immediately

ASSISTANT EXECUTIVE SECRETARY

The Assistant Executive Secretary will share with the Executive Secretary certain duties and responsibilities concerned with the administration of the provincial office and the work of committees.

EDUCATIONAL CONSULTANT

The duties of the Educational Consultant will be concerned with the nursing education responsibilities of the Association and with educational programs and projects initiated by the Association.

The salaries for these positions will be commensurate with the preparation and experience of the applicants accepted.

Applications or enquiries should be directed to the Executive Secretary, Registered Nurses' Association, 2524 Cypress Street, Vancouver 9, B.C.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo. 6 holidays, sick leave, 3 wk. vacation.

For further details write:
Director — Nursing Service, University Hospitals of Cleveland, Ohio.

OPERATING ROOM SUPERVISOR
for
SAINT JOHN GENERAL HOSPITAL
(400-BED)
SCHOOL OF NURSING — 150 STUDENTS

QUALIFICATIONS: POSTGRADUATE CERTIFICATION IN OPERATING ROOM TECHNIQUE & MANAGEMENT WITH EXPERIENCE.

Apply to: Director of Nursing,
SAINT JOHN GENERAL HOSPITAL, SAINT JOHN, NEW BRUNSWICK

GRADUATE NURSES — SUBURBAN TORONTO

Are invited to enquire re: employment opportunities in a well-staffed new 125-bed hospital in suburban west Toronto. General duty salary range: $240-$290 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST. WESTON, TORONTO 15, ONTARIO. CHerry 4-5551.

GENERAL DUTY NURSES
(for all departments)

Gross salary: $235 per mo. if registered in Ontario. $215 per mo. until registration has been established. $20 per mo. bonus for evening & $10 for night duty. Annual increment of $10 per mo. for 3 years.

44-hr. wk., 8 statutory holidays, 21 days vacation.

12 days leave for illness with pay after 1 yr. of employment.

APPLY: DIRECTOR OF NURSING, OSHAWA GENERAL HOSPITAL OSHAWA, ONTARIO.

REGISTERED NURSES

Required by several of the seventeen (17) hospitals in Saskatchewan's beautiful Northwest. This area has excellent recreational facilities. General Duty Nurses: 40-hr. 5-dy. wk. with generous paid holidays. Excellent residence facilities. Salary $260 — $320.

Superintendent of Nursing: Several required. Wonderful working conditions with first class residence facilities. Salary $300 — $385.

Further information can be obtained, & application submitted to Co-ordinator,

REGIONAL HOSPITAL COUNCIL, 1165 MAIN STREET, NORTH BATTLEFORD, SASKATCHEWAN.

TWO (2) REGISTERED NURSES

For a new modern, 46-bed hospital. — Salary $255 - $285 per month.

40-hour week, no split shifts, sick leave,
3 weeks vacation plus 8 statutory holidays, full maintenance.
Meals, living accommodation in Nurses' Residence,
and uniforms laundered for $34.50 per month.

Apply:

SUPERINTENDENT OF NURSES, KAMSACK UNION HOSPITAL, KAMSACK, SASKATCHEWAN.

CALIFORNIA

REGISTERED NURSES

(General Duty with opportunity for advancement)

New modern 112-bed General Hospital in dynamic college city in beautiful San Joaquin Valley only 2 hours from Los Angeles
Salary: $325 to begin. Differential for evening & nights.
5-day, 40-hr. wk. Progressive personnel policies.
Transportation costs to California will be reimbursed after 1-yr. service.

Send full particulars immediately to:

DIRECTOR OF NURSES, GREATER BAKERSFIELD MEMORIAL HOSPITAL
420 - 34TH STREET, BAKERSFIELD, CALIFORNIA

Nursing Home

Fully registered 18-bed private hospital. One of the oldest established in Calgary. 2-storey building in good condition. 3 sets plumbing. First class beds & equipment throughout. Well located, west end. Ideal setup for 2 nurses as partners. Owner retiring. Will take about $10,000 cash to handle, balance arranged. Exclusive agents. Please phone or write:

MR. JOHN BARCLAY, C/O P. LAWSON AGENCIES, 119 — 7th. AVENUE S. W., CALGARY, ALBERTA.
PHONE: AM. 2-5411

DIRECTOR OF NURSING REQUIRED

For new modern general hospital in Northern Ontario, duties to commence November 1, 1958. 42 adult beds, 11 bassinettes. Must have experience as Director or Assistant Director of Nursing. Salary range $349-$469 monthly. Welfare benefits available. Give details of training, experience, postgraduate studies, & references in letter to

ADMINISTRATOR, ANSON GENERAL HOSPITAL, IROQUOIS FALLS, ONTARIO.

LADY MINTO HOSPITAL, COCHRANE, ONTARIO

requires

1. Supervisors for Medical Dept. & Operating Room. Salaries according to qualifications.
2. Head Nurses for Medical, Pediatrics, Operating Room and Outpatient Departments.
3. General Duty Nurses — all departments. Ontario Registered Nurses' salaries according to the R.N.A.O. schedule.
4. Certified Nursing Assistants — all departments.

For further information apply Superintendent,

LADY MINTO HOSPITAL, COCHRANE, ONTARIO.

THE B. C. CIVIL SERVICE REQUIRES

Instructor of Staff Nursing 1
Mental Health-Services — Essondale, B.C.

Salary: $280-$330 per mo. Duties include teaching various subjects in the educational program of the School of Psychiatric Nursing. Applicants must be British subjects registered or eligible for registration with the Registered Nurses Association of B.C. Must hold a degree or diploma in nursing education & should have post basic preparation & experience in psychiatric nursing.

For further information & application forms apply to the

PERSONNEL OFFICER, CIVIL SERVICE COMMISSION, ESSONDALE, IMMEDIATELY. COMPETITION No. 58:308A.

General Duty NURSES wanted

ONTARIO HOSPITAL

Whitby

The Ontario Hospital, Whitby, is situated in pleasant surroundings 25 miles east of Toronto, 4 miles from Oshawa. All shifts are worked over a five day, forty hour week. All statutory holidays, or time in lieu, are given. Nurses are entitled to three weeks vacation after one year's service.

Pension plan and accumulative sick leave allowance are in accordance with Ontario Public Service Regulations. Gross starting salary is $240 a month if registered in Ontario. $220 a month until registration is established. Annual increments awarded.

Apply:—Miss Helen Whitmen, Reg. N., Director of Nursing, Ontario Hospital, Whitby

ONTARIO DEPARTMENT OF HEALTH

Hon. Mackinnon Phillips, M.D.C.M., LL.D., Minister

THE WINNIPEG GENERAL HOSPITAL

is recruiting

1. AN ASSOCIATE DIRECTOR OF NURSING EDUCATION:

   To supervise and assist in the organization and development of the educational program for the school of Nursing.

   Qualifications:

   a. Minimum, a B.A., or B.Sc. degree in nursing with considerable experience in supervisory and administrative capacities.

   b. Desirable but not essential, a Master's degree or equivalent education and experience.

2. CLINICAL SUPERVISORS IN MEDICINE & SURGERY
3. GENERAL DUTY NURSES FOR ALL SERVICES.

Please send applications direct to:

THE DIRECTOR OF NURSING,
THE WINNIPEG
GENERAL HOSPITAL,
WINNIPEG 3, MANITOBA.

SOUTH PEEL HOSPITAL

COOKSVILLE, ONTARIO

(12 miles west of Toronto)

Hospital opened May 15, 1958.

STAFF REQUIRED:

General Duty — for all services

Generous benefits — 40-hr. week

For further particulars apply:

DIRECTOR OF NURSING,
SOUTH PEEL HOSPITAL,
COOKSVILLE, ONTARIO.

Enjoy Western Canada's climate & hospitality

THE VANCOUVER GENERAL HOSPITAL

requires

GENERAL STAFF NURSES

1,500-bed teaching hospital, heart of British Columbia's Medical centre — new 500-bed addition opening 1959. Attractive personnel policies. Salary: $260-$300 per mo. Eligibility for registration in B.C. necessary.

Please apply to:

Personnel Department
Vancouver General Hospital,
Vancouver 9, British Columbia.

VICTORIAN ORDER OF NURSES FOR CANADA . . .

requires

PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.

Apply to:

Director in Chief,
Victorian Order of Nurses for Canada
5 BLACKBURN AVENUE
Ottawa 2, Ont.

DIRECTOR OF PUBLIC HEALTH NURSING

City of London

Must possess a Public Health Nursing degree in Public Health Administration.

Experienced in all aspects of Public Health nursing services.

Administrative & supervisory responsibility.

Duties will include planning, co-ordination of Public Health nursing services & supervision of nursing staff.

Full fringe benefits.

Salary according to qualifications & experience.

Address correspondence, including a photograph, to:

W. J. ANTHONY,
PERSONNEL OFFICER, CITY HALL,
CITY OF LONDON, ONTARIO.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic, Northwest Territories and the Yukon Territory.

SALARIES



(1) Public Health Nursing Supervisors: up to $5,220 depending upon qualifications and location.

(2) Directors of Nursing in Hospitals: up to $4,950 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $3,780 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,540 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Supervisor of Nursing, P.O. Box 430, Haute Ville, 3 Beade Street, Quebec 4, P.Q.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

Official Directory

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

Pres., Miss M. Street, Calgary Gen. Hosp., Calgary; Past Pres., Miss E. Bietsch; Vice-Pres., Sr. C. Leclerc, Mrs. D. J. Taylor, Miss R. McClure. *Committees: Nursing Service,* Miss K. Macalister; *Nursing Education,* Miss M. R. Thompson; *Finance,* Miss E. Bietsch; *Legislation & By-Laws,* Miss J. Clark. **Exec. Director, Mrs. C. A. Van Dusen, Ste. 5, 10129-102nd St., Edmonton. Registrar, Miss R. Schwindt, Ste. 5, 10129-102nd St. Edmonton.**

BRITISH COLUMBIA

Registered Nurses' Association of British Columbia

Pres., Miss E. Rossiter; Past Pres., Miss A. Creasor; Vice-Pres., Misses H. King, M. Frith; Hon. Sec., Miss E. Kunderman; Hon. Treas., Miss A. Cumming. *Committees: Legislation, Constitution & By-Laws,* Miss M. Campbell; *Nursing Education,* Miss M. Richmond; *Nursing Service,* Miss N. Wylie; *Public Relations.* Miss M. Macdonell. **Exec. Sec. & Registrar, Miss Alice L. Wright, 2524 Cypress St., Vancouver 9.**

MANITOBA

Manitoba Association of Registered Nurses

Pres., Mrs. H. C. Mazerall, 10 Wildwood Park, Winnipeg 9. **Executive Secretary & Registrar, Miss L. E. Pettigrew, 247 Balmoral St., Winnipeg 1.**

NEW BRUNSWICK

New Brunswick Association of Registered Nurses

Pres., Miss L. O. Smith, Provincial Hospital, Lancaster; Past Pres., Miss G. B. Stevens; Vice-Pres., Miss K. MacLaggan, Miss S. Miles; Hon. Sec., Sr. Theresa Carmel. *Committees: Nursing Education,* Miss D. Grieve, General Hosp., Saint John; *Nursing Service,* Miss M. J. Anderson, Victoria Public Hosp., Fredericton; *Advisory to Schools of Nursing,* Miss M. Hunter, 670 Regent St., Fredericton; *Finance,* Miss K. MacLaggan, 385 Union Street, Fredericton; *Legislation & By-Laws,* Miss S. Miles, Lancaster Hosp., Lancaster; *Public Relations,* Mrs. B. Norris, Box 55, Newcastle. **Sec.-Registrar, Miss M. Archibald, 231 Saunders St., Fredericton.**

NEWFOUNDLAND

Association of Registered Nurses

Pres., Miss J. Story, 337 Southside Rd., St. John's; Past Pres., Miss E. Summers; Vice-Pres., Miss J. Lewis, Brig. H. Janes, Sr. M. Xaverius. *Councillors:* Major M. Lydall, Misses G. Rowsell, R. Bishop, R. Harnett, Rep. St. John's Chapter, N. Tilley, Rep. Corner Brook Chapter, Sr. M. Calasanctius, Rep. Nursing Sisterhood. *Committees: Nursing Education,* Miss G. Rowsell; *Nursing Service,* Miss H. Penny; *Finance,* Brig. H. Janes; *Legislation & By-Laws,* Miss J. Lewis; *Publicity & Public Relations,* Miss I. Sutton; *Rep.* to: *The Canadian Nurse,* Miss I. Sutton. **Exec. Sec., Miss Pauline Laracy, Cabot Bldg., Duckworth St., St. John's.**

NOVA SCOTIA

Registered Nurses' Association of Nova Scotia

Pres., Sr. C. Gerard; Past Pres., Mrs. D. McKeown; Vice-Pres., Misses M. Matheson, J. Church, E. MacLennan; Rec. Sec., Miss D. Gill. Victoria Gen. Hosp., Halifax. *Committees: Nursing Education,* Miss F. Lytle; *Nursing Service,* Mr. W. Landry; *Finance,* Miss P. Lyttle; *Legislation & By-Laws,* Sr. M. Bernadette; *Public Relations,* Mrs. H. Mack; *Discipline,* Miss M. Graham; *Credentials,* Miss E. Purdy; *Nominations,* Miss H. Munroe; *Board of Examiners,* Sr. Clare Marie. Rep. to: *Local Council of Women,* Miss M. Haliburton. **Sec.-Registrar, Miss Nancy H. Watson, 73 College St., Halifax.**

ONTARIO

Registered Nurses' Association of Ontario

Pres., Miss M. P. Morgan, General Hosp., Hamilton; Vice-Pres., Miss E. M. Howard, Mrs. M. Duncanson. *Committees: Nursing Service,* Miss E. M. Howard; *Nursing Education,* Miss H. G. McArthur; *Registration,* Miss H. A. Bennett: *Public Relations,* Miss I. Black; *Finance,* Miss I. B. Brand; *Legislation & By-Laws,* Miss J. E. Young. *District Presidents:* Dist. 1, Mrs. M. G. Smith, 1428 Lecaron Ave., Sarnia; *2,* Miss H. F. Naudett, Memorial Hosp., Listowel; *3,* Miss E. Law, 28 Cameron St., Galt; *4,* Miss E. L. M. Ferguson, Mt. Hamilton Hosp., Hamilton; *5,* Mrs. R. B. Couse, 582 O'Connor Dr., Toronto; *6,* Mrs. D. Stewart, R.R. 11, Peterborough; *7,* Mrs. A. B. Rintoul, Maitland; *8,* Miss E. M. Gordon, Apt. 110, 150 Argyle Ave., Ottawa; *9,* Miss G. O'Leary, 204 Oak Street, Sudbury; *10,* Miss D. L. Adams, 900 Arthur Street, Fort William; *11,* Miss E. J. Pittuck, Ontario Hosp., Orillia; *12,* Miss M. V. Kenney, Anson General Hosp., Iroquois Falls. **Exec. Sec., Miss F. H. Walker, 33 Price St., Toronto 5.**

PRINCE EDWARD ISLAND

The Association of Nurses of Prince Edward Island

Pres., Miss R. Ross; Past Pres., Sr. M. Irene; Vice-Pres., Mrs. V. MacDonald, Miss K. MacLennan; Hon. Sec., Mrs. D. Wonnacott, 58 Green St., Charlottetown; Hon. Treas., Mrs. R. Palmer, Box 84, Summerside. *Councillors:* Srs. M. Patricia, M. Hermina, Mmes L. MacDonald, D. Mackay, Misses M. Cox, F. MacMillan. *Committees: Nursing Education,* Miss B. Rowland; *Nursing Service,* Sr. M. Patricia; *Public Relations,* Miss H. MacLaine; *Finance,* Mrs. L. MacDonald; *Legislation & By-Laws,* Sr. M. Stanislaus; *Registration,* Miss V. Darrach. **Exec. Sec.-Registrar, Mrs. Helen L. Bolger, 188 Prince St., Charlottetown.**

QUEBEC

The Association of Nurses of the Province of Quebec

Pres., Miss Margaret Wheeler, 4442 Oxford Ave., Montreal; Vice-Pres., (Fr.) Mlles G. Lamarre, E. Merleau; (Eng.) Sr. M. Felicitas, Miss R. Chittick; Hon. Sec., Miss A. Christie; Hon Treas., Mlle G. D. Côté. *Councillors:* Mlles G. Gosselin (Dist. 2), D. Pontbriand (Dist. 4), Mme J. Morency (Dist. 6), Mlles M. Gauthier (Dist. 8), L. Couet (Dist. 10) The above constitute the *Executive Council* and are members of the *Committee of Management* together with: Mlles L. Lapointe, J. Clairmont, A. Mailloux, F. Verret, P. Levesque, M. Jalbert, D. Fortin, J. Ouimet, Misses C. Aitkenhead, G. Purcell, Srs. Barcelo, I. Forest. *Advisory Committee:* Misses J. Golden, E. C. Flanagan, C. V. Barrett, H. Lamont, E. Geiger, Mme A. Bergeron, Mlles S. Pilon, R. Aubin, Srs. Valérie de la Sagesse, St-Ferdinand, D. Lefebvre. *Committee Chairmen: Nursing Education,* Sr. I. Forest, Miss M. Allen; *Nursing Service,* Miss G. Purcell, Mlle G. Charbonneau. *Chairmen, Board of Examiners,* (Eng.) Miss F. Bryant, Queen Elizabeth Hospital, Montreal; (Fr.) Mlle J. Trudel, Hôpital Ste-Justine, Montréal. **Sec.-Registrar, Miss Helena M. Reimer. Visitor to French Schools of Nursing, Mlle Suzanne Giroux, Association Headquarters, 640 Cathcart St., Montreal.**

SASKATCHEWAN

Saskatchewan Registered Nurses' Association

Pres., Miss L. D. Willis, Ellis Hall, Univ. of Saskatchewan, Saskatoon; Vice-Pres., Miss L. Miner, 4 Bartleman Apts., Regina; Sr. M. Hildegarde, St. Elizabeth's Hosp., Humboldt. *Committees: Nursing Education,* Mrs. M. Rosso, Providence Hosp., Moose Jaw; *Nursing Service,* Miss K. Ruane, University Hosp. Saskatoon; *Public Relations,* Miss V. Spencer, 3 Canada Apts., Yorkton; *Chapters,* Miss B. Hailstone, 6 Garnet Apts., Regina. **Exec. Sec., Miss V. Antonini, 401 Northern Crown Bldg., Regina.** *(Effective October 1, 1958).* **Registrar, Miss Grace Motta, 401 Northern Crown Bldg., Regina.**

Official Directory

CANADIAN NURSES' ASSOCIATION

270 Laurier Ave., W., Ottawa

President	Miss Alice Girard, Hôpital St. Luc, Lagauchetière St., Montreal, Que.
Past President	Miss Trenna G. Hunter, Metropolitan Health Com., City Hall, Vancouver, B.C.
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General Secretary	Miss M. Pearl Stiver, 270 Laurier Ave. W., Ottawa.

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Newfoundland	Miss Janet Story, 337 Southside Rd., St. John's.
Nova Scotia	Rev. Sister C. Gerard, Halifax Infirmary, Halifax.
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Quebec	Miss Margaret Wheeler, 3015 Sherbrooke St. W., Montreal.
Saskatchewan	Miss Lucy D. Willis, University of Saskatchewan, Medical Bldg., Saskatoon.

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Quebec	Rev. Sister M. Felicitas, St. Mary's Hospital, Montreal.
Ontario	Rev. Sister Madeleine of Jesus, Ottawa General Hospital, Ottawa.
Western Canada	Rev. Sister M. Laurentia, Providence Hospital, Moose Jaw.

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Nursing Education	Miss Hazel Keeler, University Hospital, Saskatoon.
Public Relations	
Legislation and By-Laws	Miss E. A. Electa MacLennan, School of Nursing, Dalhousie University, Halifax.
Finance	Miss Helen Carpenter, 50 St. George St., Toronto 5.
Journal Board	Mrs. Isobel MacLeod, Montreal General Hospital, Montreal.

EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses, Mrs. Clara Van Dusen, Ste. 5, 10129-102nd St., Edmonton.

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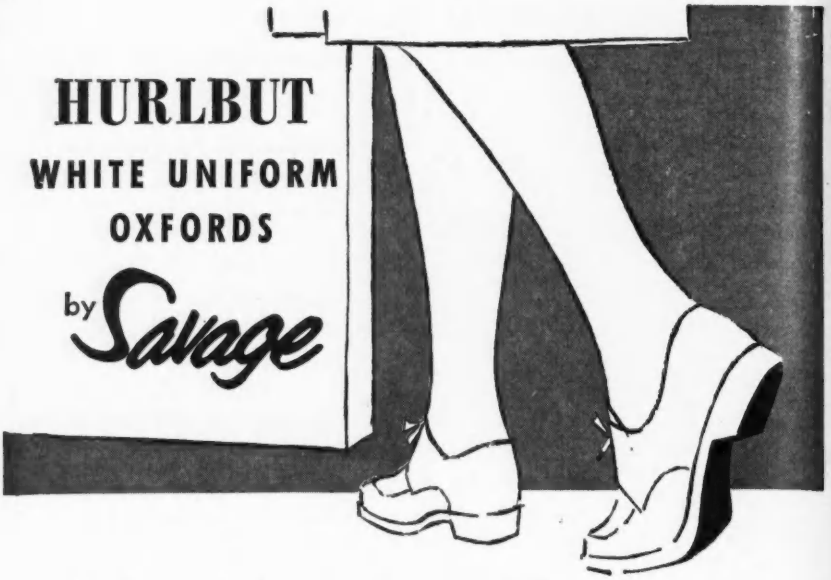
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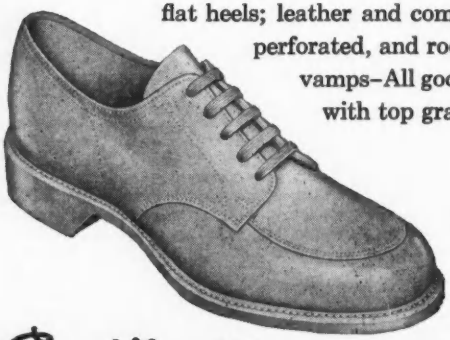
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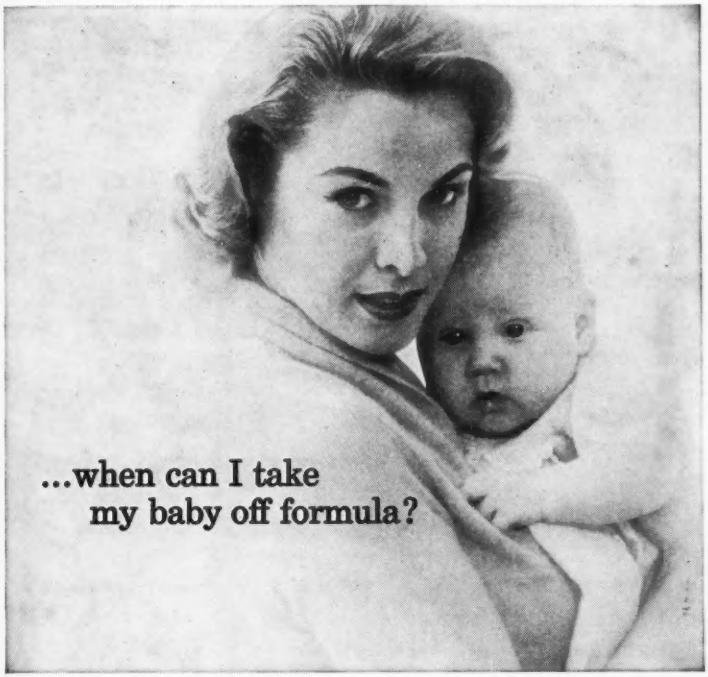
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